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The Hunterian Oration.

Delivered before the Royal College of Surgeons of England on Feb. 14th, 1905.

By JOHN TWEEDY, F.R.C.S. Eng.,

PRESIDENT OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Mr. Vice-Presidents and Gentlemen,—Before undertaking the duty to which I have been specially appointed to-day I desire to express our sense of bereavement in the loss of Mr. Luther Holden who died eight days ago in his ninetieth year. Twenty-four years ago Mr. Holden stood in this place to deliver the Hunterian Oration and those who were present will recall the gentle and genial spirit which pervaded his speech and its learning and eloquence. Within seven months this College has lost three of its past Presidents, John Birkett, John Simon, and Luther Holden, each being in turn Senior Fellow of the College. Great and varied as were the abilities and attainments of these distinguished men, and different as were the manifestations of their intellectual and professional activity, they had at least one great quality in common. Called upon to occupy exalted positions in the surgical profession and elected to the highest office in this College they, each and all, in an age of wealth and luxury, lived simple and unostentatious lives, careful only for the faithful discharge of their various duties. In this way they set a worthy example to their professional brethren and in the nineteenth century maintained the high ideal embodied in the Hippocratic oath—"In purity and in righteousness I will pass my life and practise my Art."

Hunter, the anniversary of whose birth we celebrate to-day, did not leave behind him a systematic collection of medical and surgical writings such as the first four writers I have named, nor did he make any capital discovery, such as Harvey's, respecting the circulation of the blood; but the influence which he exercised upon biology and upon surgery was perhaps more immediate and more penetrating than that of any of his predecessors and it has been more continuous and more progressive.

Harvey's discovery was *sui generis* and well deserves the eloquent characterisation of Haeser as "the most brilliant triumph of experimental physiology." In all essential respects it was definitive and final. "A demonstrated truth," says Aristotle, "is an eternal truth," and such was Harvey's. It changed the conceptions of physiologists and physicians as completely as Kopernik's heliocentric theory changed those of astronomers; and it became the starting point of modern progress in physiology, medicine, and surgery. Thanks to the labours of Harvey, supplemented and completed by the discovery of the capillary blood-vessels by Malpighi and the discovery of the chyliferous vessels by Aselli and Pecquet, physicians and philosophers were enabled to look upon man and his organism, upon structure and function, upon nutrition and growth, and upon the problems of health and of disease from a new point of view.

Throughout the ages of civilisation the growth of knowledge has been slow and often irregular, but it has been continuous and it has been sure. How slow and yet how sure we may realise by comparing the dialectic notions of Aristotle respecting weight and motion with the direct appeals to the evidences of the senses afforded by the demonstrations of Galilei, whereby it was shown that so far from there being in nature bodies possessing positive levity, all matter is equally affected by gravity, irrespective of its form, magnitude, or texture. By the simple experiment of dropping objects from the Tower of Pisa, Galilei, who began life as a medical student, laid the foundation of modern physical science and especially of dynamics. This expedient was one of the first appeals, at least in modern times, to the use of direct experiment in physical science and the truth thereby established became a determining factor in Newton's great discovery of the law of gravitation. From Aristotle to Galilei an interval of more than 18 centuries had elapsed. Galilei and Harvey were contemporaries. John Hunter was born exactly a century after the publication of Harvey's *Exercitatio de Motu Cordis*. It is one hundred and eleven years since John Hunter died. Yet how modern Hunter is. Inventions and discoveries now crowd upon us so thick and fast that we are apt to forget how recently modern physical science began and especially modern medicine. In the order of time medicine, in its rudest and simplest forms, must have been one of the first of the empirical arts, but in the order of ideas it was one of the last to enter into the hierarchy of the sciences. As a system of organised knowledge medicine pre-supposes and requires not only centuries of clinical observation and a complete logical apparatus, but it also requires an advanced state of all the other natural sciences. It concerns itself with the recondite problems of life in the most complex and the most highly differentiated of its manifestations, whether under the conditions of health or under those of disease. Until physics and chemistry had advanced from the conjectural and the *aprioristic* to the scientific stage medicine could only be conjectural and *aprioristic* too, however useful it may have been as a practical art. The thoughts and labours, the experiments and discoveries of the great pioneers of modern knowledge in the physical sciences were the necessary prelude to a scientific progress in biology which in its turn was a condition precedent to any real advance in the science of medicine, surgery, and pathology. Harvey in the order of time and of thought was the necessary antecedent of Hunter.

The history of John Hunter's birth and parentage is well known. The starting point of John Hunter's career as anatomist, biologist, and surgeon was in the year 1748, when he came to London with a receptive and intelligent mind, a quick and observant eye, and a well-trained hand, to collaborate with his brother William in the anatomical school which had been started two or three years before. It has been alleged that John Hunter had little or no school education and that he was a wayward and careless youth; and it has been argued that his lack of scholastic training hampered him in after life, more particularly with reference to his powers of verbal description and exposition. I suspect, however, that the defects of Hunter's general education have been exaggerated. It is certain they had no detrimental effect upon the vigour of his intellect or upon the correctness of his methods of work. John Hunter probably knew little, perhaps he knew nothing, of formal logic or of the history of ideas or of scientific methods, but with the instinct of true genius he soon found the only path that leads to genuine knowledge and he kept it undeviatingly to the end. Contrasts have often been drawn between John Hunter and his brother William and the differences between the two men have usually been ascribed to a difference in education. This, I believe, is not the correct, and certainly it is not the only, explanation. There was a difference between the two brothers but it was a difference of temperament and disposition, a difference which was only indirectly, if at all, determined by education. Be this as it may, the differences were subdued to a great purpose. The qualities of the two brothers became complementary one of the other. The manipulative skill and the tireless research of John furnished ample materials for the display of William's splendid powers of exposition and so each in his own way contributed to the success and fame of the first and greatest school of anatomy in England.

Considering the important part that human anatomy now plays in medical education it is difficult to conceive that there was no systematic teaching of anatomy in England before the middle of the eighteenth century. During the many centuries which elapsed between, say, the time of Hippocrates and the middle of the sixteenth century the dissection of the human cadaver was almost unknown. Forbidden alike by the laws and customs and religion of the ancient Greeks and by the creed of Mohammad, the study of human anatomy was placed under a civil and religious ban until the end of the thirteenth century. In ancient Greece the laws relating to immediate burial were very stringent. Even victorious generals had been condemned to death because they neglected to bury the slain. The pathos of Sophocles's tragedy of Antigone turns, it will be remembered, upon the sacredness of the dead and of the necessity, higher than imperial commands, of immediate burial.

When the tradition of Greek medicine passed, in the seventh and eighth centuries, into the hands of the

Mohammadans human anatomy was equally neglected, the practice of dissection being implicitly forbidden by the Qurán. Albucasis, the only surgeon of first rank in the Græco-Arabian school, writing at the end of the eleventh century, deploring the decadence of surgery, says: "The reason why there is now no dexterous operator, is this:—The medical art demands time. He who wishes to practise it ought first of all to study anatomy as it is described by Galen." Albucasis cites several instances within his own knowledge of patients dying from hæmorrhage under the hands of men who had undertaken to operate without knowing where the large blood-vessels lay or how to arrest the bleeding when these vessels were divided.

Even after the dissection of the human cadaver received the sanction of the civil authorities in Southern Europe the teaching of anatomy was cursory and occasional and merely descriptive. Mundino of Bologna in the fourteenth century, who was the first in modern times to dissect the human cadaver, seems to have dissected only two bodies. So little was known of human anatomy and so strong was the tyranny of tradition, that when Vesalius in the middle of the sixteenth century alleged that the anatomical descriptions of Galen could not be adapted to man there were not a few, in their zeal to repel the accusation that Galen had used animals in dissection, who did not hesitate to maintain that the human organisation had changed since Galen's time. In England, notwithstanding Harvey's lectures on anatomy in the first quarter of the seventeenth century, there was no organised teaching of anatomy before William Hunter's time. In this matter William Hunter has not received all the credit he deserves. He came to London in the year 1741, at a critical period in the history of English surgery. In the year 1745 the union which had existed between the Surgeons of London and the Barbers of London for over 200 years was dissolved by Act of Parliament. The surgeons were incorporated by the name of the Masters, Governors, and Commonalty of the Art and Science of Surgeons and from this incorporation our College took its rise. During the union of the two companies there had been lecturers or readers on anatomy in the Barbers-Surgeons Hall, the readers being nearly all physicians, but the teaching of anatomy seems to be for the most part only descriptive and demonstrative. Upon the formation of the new Company of Surgeons provisions were made for the teaching of anatomy but the first masters were not elected until eight years later. There seems to have been throughout the greatest difficulty in getting the stewards of anatomy to perform their duties and partly in consequence of this and partly in consequence of the difficulty of obtaining "bodies" the attempt to teach anatomy was abandoned by the Surgeons' Company.

In the winter of 1745–46 William Hunter undertook for a Society of Naval Surgeons the delivery of a series of lectures on surgery. This he did so satisfactorily that he was asked to include anatomy in his course. He accordingly advertised his first course of anatomical lectures to begin Feb. 1st, 1746, and added that "the operations of surgery, with the application of bandages," would be included in the course; and also, that "Gentlemen may have an Opportunity of learning the Art of Dissecting, during the whole Winter Season, in the same Manner as at Paris." Had William Hunter's ambition been realised he would, nearly a century and a half ago, have solved a problem in early medical education in London which is still perplexing the minds of many thoughtful persons. He desired to establish an anatomical school in London upon an extensive scale. With this object in view he offered to erect a building at the cost of £7000 for the study and teaching of anatomy, provided the Government would grant him a piece of ground to build upon. It was also his intention to give to this institution all his preparations and his books. With an unfortunate lack of sympathy which British Governments have too often manifested in their dealings with science and education William Hunter's offer was declined. Smarting under a keen sense of disappointment and full of resentment he determined to transfer his favours to Glasgow, which now enjoys the possession of his priceless museum and library. *Beati possidentes.*

William Hunter's memory deserves at least this passing tribute of our respect. He attempted to place medical education in London on a sound and permanent basis. But we of this College owe his memory a further debt of gratitude, for he was John Hunter's early patron and protector and took every occasion and opportunity to advance John's worldly interests and to promote his reputation in the surgical and the scientific worlds.

After John Hunter had worked at human anatomy for about ten years he manifested his intellectual growth by directing his thoughts to the higher and more scientific discipline of comparative anatomy and physiology. He realised that human anatomy alone was an insufficient guide to pathology and surgery. He collected all manner of animals at his house and grounds at Earl's Court in order to study their ways and habits and from every available source he acquired animals, living or dead, for the purposes of observation, experimentation, or dissection. In his use of the lower animals for the elucidation of physiological problems he followed while amplifying the practice of Harvey, who in his turn adduces the authority of Aristotle. There was, however, a striking and characteristic difference between the use which Aristotle made of the dissection of animals with reference to human anatomy and that of Hunter. There is no trustworthy evidence that Aristotle or Hippocrates or even Galen dissected the human body, certainly not in the sense we understand by the term "dissection." They dissected the bodies of animals *instead of* those of man and transferred their observations of animals to the corporeal organisation of man. Hunter, on the other hand, practised the dissection of lower animals *in addition to* that of man and transferred his observations to the embryology and morphology of man and to the elucidation of the problems of human and comparative physiology and pathology.

John Hunter was a philosopher in the strict and primary sense of the word. He had a passion for knowledge. "Let no man presume to call himself wise," says Pythagoras. "God alone is wise. Man can never get beyond the passion for wisdom." John Hunter had this passion. He devoted himself to the pursuit of knowledge, searching for it in every department of the organic world, animal and vegetable. In one of his letters to Jenner he says: "I have but one order to send you, which is, to send everything you can get, either animal, vegetable, or mineral, and the compound of the two, either animal or vegetable mineralised." And, again: "Have you any large trees of different kinds that you can make free with? If you have, I will put you upon a set of experiments with regard to the heat of vegetables." With respect to the observations and experiments which he directs Jenner to make he says, "Be as particular as you possibly can." These sentences express briefly and in epitome, as it were, Hunter's habits of mind and his attitude towards the problems of organic life.

John Hunter may have lacked the power of clear exposition and he may have disliked routine teaching. He was, however, full and overflowing with ideas, new and original, to which he often found it difficult to give distinct shape and utterance. In contrast with William Hunter's didactic powers John had the suggestive, the constructive, the creative faculty, the faculty of discovery, of coördinating knowledge, and he had the art of stimulating thought and calling forth effort from others. He taught by example rather than by precept. It is clear evidence of the value of John Hunter's method of teaching that he attracted to his classes the best students and surgeons of his day, men who afterwards rose to the highest eminence—Edward Jenner the vaccinator, Dr. Physick of Philadelphia, Abernethy, Cline, James Earle, Astley Cooper, Lynn, and Anthony Carlisle. These men in after life repeatedly expressed their indebtedness to Hunter and to his personal influence as a teacher.

What, then, did Hunter do? The ready answer comes that he made one of the largest and most instructive collections of anatomical and biological specimens known to history: his famous museum, which is now lodged within the walls of this College and which it is our pride and privilege to protect, to preserve, and, so far as may be possible, to perfect. But I venture to think that however great, notable, and precious Hunter's museum may be it represents only the material part of him. The spirit which animated him, the germinative character of his method, the impulse which he gave to the operation of mind in the pursuit of biological knowledge were infinitely greater and infinitely more precious. *That*, amid the accidents and mischances of time may pass away, but *these* will abide as long as civilisation on this earth endures. What Hunter did from the material side is sufficiently well known. His contributions to surgery and biology have been repeatedly enumerated, expounded, and eulogised in this place and elsewhere. I shall, therefore, not attempt to repeat what has been already

done so often and so well but I desire rather to draw attention to Hunter's method—to consider not so much *what* he did as *how* he did it.

Ottley, the first and one of the best of Hunter's biographers, remarks that in pursuing his researches Hunter strove not, like many of his more learned and less philosophical predecessors, to unravel the mysteries of Nature by taking up principles *a priori* and seeking for facts to support his theory but that, on the contrary, he followed in the strictest manner the inductive method laid down by Bacon as the only sure though arduous road to knowledge and Babington, in his Hunterian Oration, remarks of him: "He had never read Bacon but his mode of studying Nature was as strictly Baconian as if he had." Other critics and historians of Hunter's work and not a few Hunterian orators have written or spoken in a similar strain. In my judgment this opinion is entirely erroneous with respect to Hunter's method and it is a complete misinterpretation of the Baconian system. Bacon's eloquence and influence undoubtedly did much to attract men to the study and observation of natural phenomena. He called attention to the necessity of studying the powers and forces of the world as a means of subjecting the world to the human mind and so far his message was appropriate and opportune. The significance of that message is probably greater now than at the time he delivered it. The future belongs to the nation which understands best the forces of nature and which can most skilfully and economically employ them. But Bacon himself neither knew nor understood the physical sciences. His spirit was essentially mediæval and much less modern than that of his illustrious namesake Roger Bacon who lived 300 years before him. Francis Bacon's aim was purely utilitarian. He had no idea of knowledge for its own sake and he cherished the hope that by increasing our knowledge of nature the secret of the transmutation of substances would be learnt and probably the knowledge of the making of gold. He not only had no practical acquaintance with natural science but he lacked insight into the true methods of its investigation. He understood very imperfectly the value of the experimental method and assigned a subordinate position to quantitative determination, the precise quality which is the most striking characteristic of modern science and which constituted the most original and perhaps most brilliant of the reasonings which Harvey employed in his famous Induction. So far from being the founder of the modern scientific method Bacon's writings were themselves one of the products of the intellectual awakening which began at the end of the sixteenth century. Notwithstanding his affectation of scientific knowledge and scientific methods Bacon had an unscientific weakness for superstitions. He believed in natural and judicial astrology, through not without some hesitation and discrimination. He believed in the transmutability of elements and of the metals, in charms and signatures as remedies, and so completely did he ignore Harvey's discovery of the circulation of the blood that in one of the latest of his writings he ascribes the pulsation of the heart and arteries to the dilatation and contraction of the spirits. Well might Harvey say, in disparagement of Bacon's scientific writings: "He writes philosophy like a Lord Chancellor."

Bacon's ruling idea was the collection of masses of facts and then the employment of processes of arrangement and separation and exclusion so artificially contrived that a man of common intelligence should be able to announce the truth sought for. This method has been slightingly described as a kind of scientific bookkeeping. "It is difficult," says Stanley Jevons, "to imagine a less likely way of arriving at great discoveries. The greater the array of facts the less is the probability that they will by any routine system of classification disclose the laws of Nature." The answer to the claim that Bacon was the philosophic father of modern methods of scientific investigation is that none of the scientific truths established by the great masters of science can be made even to *appear* in correspondence with Bacon's methods. Whether we look to Copernicus who preceded him, or to Kepler, Galilei, Torricelli, Pascal, Gilbert, and Harvey, or to Newton, Descartes, or Huygens, or to Thomas Young, or to the chemists Black, Priestley, Scheele, and Lavoisier, we find that discovery was achieved by a method quite different to that advocated by Bacon. So dispassionate a critic of philosophy as John Grote remarks: "I have not the smallest belief in Bacon's having reformed the method of discovery, believing rather that if he had had any success in that way in the manner he wished it would have been most calamitous for science." And even with regard to the claim of Bacon to be the founder of inductive philosophy, Ellis, one of the ablest of his editors, asserts that the nature of the act of induction is as clearly stated by Aristotle as by any later writer, while Aristotle himself ascribes the credit to Socrates. Perhaps the Baconian claim has never been more convincingly refuted than by Augustus De Morgan, at once one of the profoundest and subtlest thinkers of the nineteenth century. "Modern discoveries," he says, "have not been made by large collections of facts, with subsequent discussion, separation, and resulting deduction of a truth thus rendered perceptible. A few facts have suggested an hypothesis which means a supposition proper to explain them. The necessary results of this supposition are worked out and then, and not till then, other facts are examined to see if these ulterior results are found in nature. ..... Wrong hypotheses rightly worked from have produced more useful results than unguided observation. But this is not the Baconian plan. ..... What are large collections of facts for? 'To make theories *from*,' says Bacon; 'To try ready-made theories *by*,' says the history of discovery."

Bacon's plan was purely mechanical. He ignored the work of the mind in the constitution of knowledge. He imagined that he had discovered a method by which scientific truth might be determined with absolute certainty and by a mechanical mode of procedure such that all men were capable of employing it. "Our method of discovering the sciences is," he says, "one which leaves not much to sharpness and strength of wit but nearly levels all wits and intellects." And this opinion is endorsed by most writers of the empiricist school, in complete disregard of the teachings of history. Those who imagine that science requires nothing but the registering and classification of facts forget that the facts observed can only be connected and related by the mind and that the laws of nature are after all mental products from given data.

Not only did John Hunter not follow the mechanical methods of Francis Bacon but it is the work of the mind which is the peculiar characteristic of his method and its chief glory. Others could do as well as he the more mechanical part of his task, indeed much of it was done by others; but the suggesting, controlling, coördinating mind was Hunter's, which, amidst the multiplicity of phenomena and of data apparently conflicting, discovered unity amidst multiformity, which is the special function of science.

John Hunter's constant aim was to arrive at principles and he was distrustful of so-called facts. "The principles of our art," he said, "are not less necessary to be understood than the principles of other sciences; unless, indeed, the surgeon should wish to resemble the Chinese philosopher whose knowledge consisted only in facts. In that case the science must remain unimproved until new facts arise. In Europe philosophers reason from principles and thus account for facts before they arise."

Hunter possessed every moral and intellectual qualification necessary for fruitful scientific research. He had a large knowledge of facts based on an intimate acquaintance with the phenomena of organic nature. He had a fertile imagination ready to suggest possible relations of those facts. He had openness of mind and a conscientious scientific spirit which submitted every hypothesis to the test of observation and experiment. Scepticism is the first condition of reasoned knowledge. Hunter was not only observant but he was rationally sceptical and critical and he himself ascribed his success as a scientific investigator to the sceptical qualities of his mind. He took nothing on trust. He was always careful to distinguish between mere conjecture and reality and drew a sharp distinction between the actual results of an experiment physically performed and what might have been mentally anticipated. "In pursuing any subject," he says, "most things come to light as it were by accident—that is, many things arise out of investigation that were not at first conceived, and even misfortunes in experiments have brought things to our knowledge that were not, and probably could not have been, previously conceived; on the other hand, I have often devised experiments by the fireside or in my carriage and have often conceived the result; but when I tried the experiment the result was different or I found that the experiment could not be attended with all the circumstances that were suggested." Here, in a sentence, we note the wide difference between the modern and the mediæval spirit

in science. The alchemists performed experiments innumerable, but with them theory ranked above experiment and if experiment gave an unexpected result this was forced into an artificial conformity with the *aprioristic* theory. It was therefore, says Lange in his "History of Materialism," "essentially directed to the production of this previously anticipated result rather than to free investigation."

Many of Hunter's discoveries may be said to have been accidental but they were such accidents as happen only to those who deserve them, as Lagrange remarked of Newton. Chance may sometimes put us in the right way but chance alone does not takes us far. It was chance that showed to Ambrose Paré in the sixteenth century that gunshot wounds did not need the application of boiling oil, as he had learned from his masters and as he himself at one time believed. Paré states that when he went to the wars in 1536 he had neither seen war nor gunshot wounds and only knew what he had read in John of Vigo who taught that gunshot wounds were envenomed and that the effect of the poison was only to be counteracted by pouring boiling oil into the wound. Paré, relating his later experiences, states that on one occasion there was not enough boiling oil to cauterise all the wounded, and he used instead for some of the cases a digestive made of yellow of egg, oil of roses, and turpentine. The shortage of the boiling oil caused Paré great distress of mind as he feared that those who had not had the application of the oil would die from poisoning. After a sleepless night he rose early in the morning and was surprised and rejoiced to find that those who had had the milder application had not only not died but that they were suffering but little pain and the wounds were free from swelling, whereas, those who had had the orthodox cauteri-ation were suffering severely from pain and swelling of the limb and from fever. Henceforth he decided to abandon the barbarous use of boiling oil. But not content with the accidental experience he proceeded in the true scientific spirit to test the alleged venomous quality of gunpowder and proved that not only was it non-poisonous but that it might be used with good effect to ulcers in order to dry them.

In a sense it was chance that disclosed to Hunter the establishment of collateral circulation after the ligature of a main artery. In July, 1785, Hunter tied one of the external carotid arteries of a stag with a view of studying its effects upon the growth of the corresponding antler. He observed that the pulsations of the vessels of the "velvet" ceased and that the antler, which was only half-grown, became cold to the touch. Hunter debated within himself whether the antler would be shed or be retained longer than usual. On examining it a week or two later, when the wound had healed, he found that the antler had become warm and was increasing in size. The question was—Had his operation in some way been faulty? The buck was killed and on examination it was found that the artery had been duly tied and was completely obliterated but that the circulation was carried on by vessels above and below the ligature, which had, under the new conditions, become enlarged and by their anastomoses had restored the blood-supply of the growing part. The knowledge of the establishment of collateral circulation was not new in the history of surgery. Blood-vessels had often been divided and tied in continuity and the nutrition of the limb had not been permanently impaired. Indeed, Celsus, writing in the first century of our era, distinctly states that after a division of a large artery the two ends should be tied and that repair takes place by anastomosis. But Hunter now saw from a new point of view the establishment of collateral circulation after the ligature of a large artery. He readjusted his conceptions. His sagacious insight discovered a deeper meaning in this chance observation and he conceived its applicability to the treatment of, at least, popliteal aneurysm. It so happened that there was a patient under his care in St. George's Hospital with popliteal aneurysm who had consented to undergo amputation. Hunter argued that if the anastomosing vessels in man would carry on the circulation after ligature of the femoral artery as it had done in the artery of the stag he could cure the patient's aneurysm and save the limb. Hunter performed the operation and in six weeks the patient left the hospital cured and with a sound limb. This operation, which has ever since borne Hunter's name, has been instrumental in saving hundreds of limbs and lives.

While the principle underlying this operation was originally suggested by a chance observation, its elaboration and perfection were only possible by a mind stored with clinical experience and emboldened by assurance gained through experiments on living animals. Hunter constantly submitted his observations to verification and, whenever practicable, to the test of experimentation, which Cossa describes as "observation carried to a greater degree of perfection." Hunter did not unnecessarily repeat experiments. It was an axiom with him "that experiments should not be often repeated which tend merely to establish a principle already known and admitted but that the next step should be the application of that principle to useful purposes."

While Hunter was intolerant of a state of doubt in small things as in great, if by any means decision was possible, he ever held his judgment in suspense if certainty was not attainable. Like all strong characters, he cared little for systems or consistencies of opinion. He followed wherever Truth should lead and by his very nature was always open to new and higher knowledge. To a pupil who asked with surprise whether he had not the year before stated an opinion on some point directly at variance with one he had just put forth he boldly replied: "Very likely I did; I hope I grow wiser every year." And again, "Never ask me what I have said, or what I have written; but if you will ask me what my present opinions are I will tell you."

In all his relations of life John Hunter manifested courage, candour, and tenacity of purpose. Truth he believed to be preferable to friendship and at the most painful crisis in his life did not shrink from putting into practice the Aristotelian maxim. Indeed, Hunter possessed not a few qualities in common with the great Stageirite. Hunter was not, of course, Aristotle's equal either in range of knowledge or in intellectual power. Aristotle did indeed take all knowledge to his province. Hunter had not the sweep of thought, nor the largeness of view, nor the grasp of logical and philosophical principles, nor the cyclopædic learning which distinguished Aristotle; but within his range Hunter's insight was as penetrating and as clear, and his zeal for knowledge was as ardent and as untiring, and his methods were sounder, more critical, and more exact.

Ordinary men are to be measured by the standard of their contemporaries but the greatest men are estimated by the influence they exert upon the thoughts and activities of those who follow them. Judged by either or both of these criteria John Hunter ranks amongst the greatest. The time in which he lived was a period of great intellectual and scientific achievement. He had for contemporaries amongst his countrymen Priestley and Black, Cavendish and Davy, Dalton and Thomas Young, Wollaston and William Herschell, and Hunter ranked high among the highest.

In attempting an appreciation of John Hunter's method I have suggested rather than explained the development and growth of the modern knowledge of physics, chemistry, and biology under the influence of the experimental method, but it has not been my purpose or intention to offer any defence of this method. To defend the use of experiment in physics and in chemistry would be manifestly absurd and, I assume, that in this place and before this audience it is equally unnecessary to offer an apology for its use in physiology and pathology. I opine, however, that it is within my province as Hunterian orator to anticipate the possible censure of some who would not hesitate in the sacred name of Religion to traduce the memory of Hunter because he practised experiments in physiology. John Hunter did employ the method of experiment. He employed it with no less zeal than with intelligence. He employed it not from idle curiosity, not from the promptings of vainglory, nor for the purposes of worldly advancement: all that he had he gave to science. He employed it in the service of humanity and in the study of the nature and laws of life, and the knowledge which he thereby acquired he transferred to the domain of medicine and surgery and applied to the alleviation of sickness and suffering among animals no less than among men.

I pretend not either impiously to affirm or not less impiously to deny all the purposes of Infinite Wisdom in giving man dominion over the fish of the sea and over the fowl of the air, and over every living thing that moveth upon the earth; but we do know that throughout historic time man has not hesitated to capture, to subjugate, and to slay beast and bird and fish, for his pleasure, his sustenance, and his service. Was the lordship over the animals given to man only for the satisfying of his physical and sensuous needs? Is not the life more than food? Was it only with reference to man's bodily well-being that the question was asked: Are ye not of much more value than the birds of the

heaven? Does the mind need no aliment? And is the veto to be applied only when animals are to be used for the purposes of elucidating the kindly functions of physiology or of disclosing the baneful secrets of disease?

The vicarious suffering and sacrifice of animals for the service and the salvation of man have obtained throughout the ages and constituted the basis of the elaborate ceremonial system of the ancient Israelites. In anticipation of the great Passover Moses directed the Israelites each to kill a lamb according to their families and to sprinkle its blood upon the lintel and the two side posts. "For the Lord will pass through to smite the Egyptians; and when He seeth the blood upon the lintel, and on the two side posts, the Lord will pass over the door, and will not suffer the destroyer to come into your houses to smite you." The complete purification of *one* leper and his reception back into society involved not only the slaughter of three lambs but the convalescent had to appear with two living clean birds one of which was slain while the other, still living, was baptised in the dead bird's blood and then allowed to fly away free. The principle of substitution was actualised in the ceremony of the scape-goat. At the annual Feast of Expiation a young bullock, two kids, and one ram were slain; and two goats were taken upon which lots were cast, one lot for Yahwè, the other for Azazel. The goat on which the lot fell for Yahwè was sacrificed for a sin-offering; but the goat upon which the lot fell for Azazel was presented alive, and when the high priest had symbolically placed upon its head the sins and transgressions of all the people, the goat was led into the desert there to become the victim of hunger and thirst and the prey of ravenous bird and beast.

Are these hecatombs to be regarded as of Divine origin and sanction, while the inoculation of a cat or dog, or it may be a rat, is to be denounced as a desecration and a violation of the purposes and will of God? Who will say but that in our day, as the Angel of Death passes through the land, seeing upon us the sprinkling of the immunising blood, takes that for a token, and is not suffered to come into our houses to smite us? "Dipt in his fellow's blood the living bird went free"; and so we, dipped in blood, aye, the blood of our fellow-man, as the annals of Medical Martyrology bear witness, we enjoy a growing freedom from plague, and pestilence, and noisome disease and in the fulness of knowledge the measure of our freedom will be full.

The Lettsomian Lecture

ON

FUNCTIONAL MENTAL DISORDERS.

Delivered before the Medical Society of London on Feb. 6th, 1905,

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MR. PRESIDENT AND GENTLEMEN,—In taking the subject of functional nervous or mental disorders I am going upon dangerous ground, for there is a vast difference of opinion as to what is meant by functional disorders. Before coming here I looked up what the Oxford Dictionary said about "function" and "functional." "Function is the mode of action which fulfils its purpose." Functional is defined as "affecting the functions only, not structural or organic." Maudsley, who is considered a purist in the English language, says "functional disease," not functional disorder, "such as epilepsy, chorea, and neuralgia." That, therefore, is the definition of the subject. I have to deal mainly with disorders that are not associated, directly at all events, with any recognised material change in the nervous centres. Functional has sometimes been looked upon as the equivalent of volitional; for instance, every hysterical person was looked upon as a person who was deficient in will; I shall have to refer freely to hysterical conditions, but it will not do to say that functional and volitional are equivalent.

Having given you some definition of function I will now give some definite of mental disorder. In mental disorder I include a great deal more than insanity as it is generally considered. The Right Hon. A. J. Balfour, at the meeting of the British Association for the Advancement of Science last year, pointed out the limitations of science; he pointed out that the organs of sense which were the gauges as it were of truth were themselves but the results, the evolved results, and the experiences of the very impressions which they had from without. Therefore the senses that were supposed to be the ultimate judges of all truth were themselves but the outcome of the impressions which were received from the things which they were to judge. In the same way we talk about sanity and insanity and the gauge of sanity is exactly in the same position that the senses are in relationship with science.

Functional disorders, the so-called hysterical, may be divided into certain groups. For instance, we have a muscular group, we have what might be called muscular hysteria, in which there is paraplegia, monoplegia, or aphonia. Or you may find defective control as in those cases of malleation and monotonous movements which are met with in truly hysterical conditions. The functional relationship of some of these disorders with their nervous and mental disorders is shown by what I have called alternation. A patient who was admitted into Bethlem Hospital in a maniacal condition was found one day to be paralysed in her lower extremities and perfectly sane. Later she again became maniacal and at once lost the paraplegia; again later she lost the paraplegia and became maniacal. It may be the same with the muscular activity that is met with in some cases of disordered hysterical movement.

Passing from the hysterical muscular conditions and allied mental stages one has to recognise the sensory ones. And it is interesting to note the various paræsthesiæ and anæsthesiæ that are met with in hysterical cases. Among the more advanced cases I have seen malingering people who have perpetrated serious injuries to themselves apparently without feeling them, border-line cases between hypochondriacal melancholia and insanity; at all events they are cases of temporary mental disorder in which there is no direct nervous central change to be discovered.

Comparable with those cases of loss of feeling are those patients who have done peculiar things and yet say they have no memory of them whatever. I believe a large proportion of hysterical people have a direct memory of what they have done but I am equally certain that there are a number who are as completely free from memory as they are free from power to move when they are hysterically paraplegic. There are endless conditions that are inexplicable from our point of view and yet certainly are not to be traced to any definite central disease of the nervous system. The sudden cures that occur under faith-healing and at Lourdes are cases that are associated with functional and not organic nervous disorder. One cannot understand either the one or the other curing an absolute disease and I would propound this question: Are all sudden cures occurring in any forms of mental or nervous disorder to be looked upon as evidence that they were functional and not organic?

I have already mentioned that there may be an alternation between mental disorder of the true ordinary type, such as mania and hysterical paraplegia. It is interesting to recognise that there may be similar alternations in diseases or disorders that may be still called functional. If, for instance, the person who suffers habitually from hay fever during the hay fever season becomes melancholic or disturbed mentally he does not have hay fever though living under exactly the same conditions as before this would point to both of these disorders being rather functional than organic. The same may be said of migraine; it is not at all uncommon for a patient who has been a victim of these migrainous attacks to keep quite free of them during the time he is in the asylum and when he gets well they return. It has to be recognised that certain other alternations take place that can hardly be looked upon as purely associated with functional disorder; that a man suffering from melancholia should lose that melancholia when he has a severe attack of gout; that another individual should lose his maniacal attack when he has an attack of rheumatic fever is hardly, I am afraid, to be considered evidence that gout and rheumatic fever are essentially functional nervous disorders.

At the present time the Government Commission on the Education or the Care of the Feeble-Minded is bringing before all of us who are interested in mental nervous disorders crowds of individuals who are out of harmony with

their surroundings, individuals who have no disease of their body, whose senses are perfect, who you may say have a judgment which is defective. Quite so; but at the same time each of our judgments is defective in some particular way probably. There is a large amount of mental disorder that is functional in so far as it prevents the individual from fulfilling his functions, taking his ordinary position in life. And if he fails to fulfil this purpose there is a failure in the performance of his functions.

The next thing to which I would refer is disorder of function that may lead to insanity. I think perhaps it might be well for me, in a few words, to quote two authorities on the question of function and its relationship to organs. Bristowe pointed out in relationship to functional muscular disorders that the affections here referred to are limited to a single muscle, or to part of a muscle, or to groups of muscles, and occur only or mainly at the time when "certain accustomed specific actions in which they are engaged are in process of performance, the affected muscles apparently acting normally under all other conditions and in other respects seeming to be fairly healthy." If instead of muscle mind is substituted, that covers exactly what I am maintaining. The other perhaps will be looked upon as more eccentric but more characteristic. The late Dr. Sutton in his Pathology says: "It is abuse of natural function, extreme abuse and restraining, hindering and interfering, that bring about disease. Every age of life is characterised by systematic interference. It is through our detestable systems that human misery comes about. Interference is a mistrust of functional activity. Once when I was with Sir William Gull he said to me, 'Sutton, human nature has never had a fair chance,' and it is true. The more I see of the human body the more I admire it for being able to endure so much and suffer so little. The study of pathology reveals that one and all of the functional blessings of man are abused into disease. When we are born we cry that we are come to this great stage of fools, says Lear. The mouth of the new-born babe is stuffed with sugar and butter and its belly crammed and its legs are not allowed to kick. It has indeed come on a stage of fools."

So you see in quoting from Dr. Sutton I am supported in my contention that a great deal of mental disorder depends rather upon the outside conditions than on the central conditions, in fact, in certain cases the patient is not so mad as his surroundings. Therefore I maintain that disorder of function leads not infrequently to real disease. Of the conditions said to lead to insanity the solitary confinement of the prisoner has been scarcely substantiated, but those who have been in the wards with me know how frequently I have pointed out the natural evolution, say, of "governess's disease," the exaltation of ideas, the feeling of grandeur and well-being that may naturally grow from the surroundings and not be innate in the individual. There is the governess, highly educated, very likely over-wrought, perhaps sprung from a lower station, who passed into a higher grade where she is a teacher and where she is recognised as a teaching machine, not as a human being, where she has every inducement to think highly of herself and is not able to associate with any of her fellows. The result is that she falls out of relationship with her environment, that she believes herself to be some important person.

Again, another form I have named "widow's disease." An English widow of middle age is left with a small amount of money and a family. She has to live a narrow cramped life. Things are thrown upon her which she never had to do or think of before and the consequence is that she is out of harmony with her environment and the environment tends to the mental disorder that may be associated with one form of depression or with another form of delusional insanity that people are scandalising her or taking her character away. In the same way you have only to suggest to certain sensitive minds a certain line of thought and it is surely not their brains which are responsible, primarily at all events, for the disorder which may arise.

To pass on to another group altogether, there are the so-called neurotic, the unstable people, you may say, who are pathological specimens from the first; possibly so; I can only say that the world works on two wheels, I believe—the neurotic and the gouty—and I am inclined to think that the neurotic type has to be considered not as a pathological entity but as a variety that may tend to be good, bad, or indifferent. They are characterised almost wholly by a too ready reaction to their environment. They have what might be called exaggerated mental reflexes and here we come to the impulsive classes. I suppose we have not got far enough in pathology. Though we talk about nerve currents and nerve storage as if we know all about the batteries and the wires that conduct them, and though we talk about discharges in epilepsy and the like for convenience, yet I fail to recognise that as a material pathology. And when referring to Maudsley's definition of functional disease, including epilepsy, I feel strengthened in my contention that I am right in including the neurotic. The neurotic interests one in many ways. First of all his instability, his tendency to impulse. The neurotic child often has a dread of heights and has a dread of moving bodies. The neurotic adult often has the same. The healthy adult when he gets run down may have the same. The senile person may have exactly the same instability, this tendency to exaggerated mental reflexes. It is a very little step between the nervous dread and the extreme nervous sensibility that one meets with in certain cases. I have not time to consider what may be compared to impulses such as obsessions, fixed ideas—which morbid ideas may be recognised by the patient to be morbid.

Now comes perhaps one of the most difficult groups of cases to understand and I must claim for this group that they should be considered as functional, not as organic. They are not common cases. During one period they are, as you might say, without control. They say exactly what comes into their minds or as it is expressed on the tip of their tongues, whether it is polite or impolite, but there are no delusions, no hallucinations. Then a shake, or perhaps not a shake, and the whole thing is changed and they again become sane. Therefore are you not to believe that cases of that kind are and must be considered from some other point of view than that of disease of cells of the brain?

Before concluding I must refer to arrest of function. I remember a man who for an operation was put under chloroform. After recovering from the chloroform he seemed to be dull and apathetic. He had no delusions but he remained where and how he was placed. If he was dressed he remained dressed; undress him and he would stop in his night-gown without getting into bed. Put him into bed and he would remain there. He was simply automatic and remained in that condition for several weeks. He then woke up quite suddenly and was himself again. Then, again, I have seen following shock somewhat similar conditions in which the whole nervous functions seemed to be arrested without being destroyed or affected in any way beyond that.

To sum up my opinion, then, I would say that there are many cases in which disorder of mental function cannot be directly associated with material change in the brain or nervous system. That many cases may depend upon alterations of nutrition of a temporary character in the nerve centres, central or peripheral, I admit. That besides this there are certain disorders which depend on the disharmony existing between the nervous system of the patient and his surroundings. Such disharmony may be original and ineradicable and is met with in certain persons who seem to have been born out of due time, being only suited to primitive states of civilisation. We have to consider that there may be misjudgments of parts of the nervous system, want of will or directing power; and in saying this I do not wish to make it appear that I believe the will to be an isolated part of mind. Yet one constantly meets with instances in which there seems to be want of proper adjustment of what have been called the functions of mind. In obsessions there may exist perfect knowledge and all the necessary constituents of the mind, yet their association may be morbid, and the result may be unreasonable and impulsive action, unreasonable belief, or obsessions of ideas. Besides these we have considered cases of sudden cure and compared them with hysterical attacks, aphonia and paraplegia, which may also be recovered from suddenly. The whole subject, I allow leads, and must lead, to much difference of opinion, but if I have succeeded in laying before you some of the results of my experience I shall feel satisfied. I recognise as fully as any of you the difficulty of my position. There was a time when "functional" was a term which covered and seemed to supply the want of knowledge, but as time passed on more was wanted. But I still think the wise man investigates; it is the savage and the lunatic who are ready with explanations. Science is organised inquisitiveness and its results. But I have little patience with so-called science that looks upon everything as already within the scope of explanation. Functional disorders, not functional diseases, depend on causes, like everything else in this world, every

result has certain antecedent conditions, but when we come to consider insanity I would repeat here what appealed strongly to my Guy's class of former years, the statement that there is no such thing as insanity. Insanity, mental disorder, depends as much on the surroundings as on the individual's bodily condition. If we were all turned out like American watches, by the million, all alike, with changeable machinery and parts, it would be different. In so-called insanity, and indeed in humanity, we have to deal with constantly changing environment, different powers of adaptation, and I therefore say at once that I cannot expect to have a clear morbid pathology for all conditions which do not fall within the conventional lines of sanity.

THE EARLY SYMPTOMS OF INSULAR SCLEROSIS.[1]

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I HAVE chosen this subject because it is one of great interest and importance to all of us and it so happens that I have seen a considerable number of cases in the last few years which have impressed this on me. It is from the point of view of general medicine that I propose to speak to you, not with any pretensions to be a neurologist, because we do not in provincial towns of the size of Brighton get sufficient opportunities for the systematic study of neurology, and in these days it is impossible without that systematic study to do more than keep in touch with this subject, which is the most exacting of all the special branches of medicine and the most difficult. But it is just from the general medical standpoint that insular sclerosis is of such importance and for three good reasons. 1. Because it is, so far as my limited experience goes, considerably the commonest of all the chronic diseases of the central nervous system. 2. Because owing to the great diversity of its symptoms it may come first in the early stage under the notice of any man whatever branch of medicine he practises, whether he be a physician, or a surgeon, or a gynæcologist, or an aurist, or laryngologist, or ophthalmic surgeon. 3. Because it is by no means easy to recognise in the early stages and is extremely apt to be confounded with hysteria, if, indeed, it be not more correct to say that hysteria is not rarely the prelude to insular sclerosis. If for no other reason, insular sclerosis might well claim our attention as being the only disease which can be said to mimic hysteria, that great simulator of so many diseases. It is exceedingly difficult, as I shall try to show you later, to say in some cases where hysteria ends and insular sclerosis begins and as the disease is often spread over a large number of years it may be impossible to get a continuous clinical history. But it is of great importance to make the diagnosis as early as possible in order, on the one hand, to save a patient suffering from a grave disease of the central nervous system from being treated as a wretched hysterical creature and, on the other, to prevent a truly hysterical case from lapsing into chronic invalidism for want of active measures. I may say that it is the first of these two events which is much the most likely to happen.

1. I will now take in order the three reasons which I have given for the importance of insular sclerosis, and first as to its commonness of occurrence. I have gone through my out-patient records for the past five years and find that during that time, I have seen nine cases in which I was absolutely certain of the diagnosis, usually after watching them for some time and about eight more in which the diagnosis was doubtful. During that time I have seen 5000 new cases of all kinds in the out-patient room, so that deducting 1000 for renewed letters and cases in which I did not make the diagnosis myself the average is about 2 per 1000. In the same period I have seen, or at least recognised, only six cases of paralysis agitans, five of locomotor ataxy, two or three of general paralysis, four of cerebral tumour, and a few odd cases of syphilitic disease of the cord, progressive muscular atrophy, and some obscure nerve lesions, including a good many which were traceable to lead poisoning. It will be seen, therefore, that in this list insular sclerosis is considerably the commonest of all the important chronic diseases of the central nervous system, so far as it is permissible to make a deduction from the comparatively small number of cases. It is true, of course, that the diagnosis in the out-patient room is often hasty, but I may say that I have had nearly all these cases in the wards for a short time for more careful observation and that in the two or three which I have not thus watched the disease was quite unmistakeable. I have a strong belief that I have probably overlooked a number of examples and that the list would be considerably larger if I could review many of the cases which I have labelled neurasthenia, hysteria, and neurosis; also that it would be longer relatively to other diseases of the nervous system which are less easily overlooked and less liable to be masked by hysterical symptoms. To these nine cases I have added six that have been under my care in private for varying periods. Insular sclerosis therefore is, I believe, commoner in the out-patient room than the much more often talked of locomotor ataxy, though on the whole the latter is more easy to diagnose, if for no other reason because the age and sex of tabetic patients usually make the alternative diagnosis of hysteria, which is so easy in insular sclerosis, very improbable in tabes.

Many cases of insular sclerosis are missed simply because the human mind moves naturally along the paths of least resistance and therefore satisfies itself with the diagnosis of hysteria, which may be fairly correct if the further possibilities of the case are not overlooked; in tabes, of course, it is easy enough to overlook the correct diagnosis where the only symptoms present are lightning pains, or some visceral crisis, or an ocular palsy, but it is rare for any alternative diagnosis to be present as a possible one in the same way as the diagnosis of hysteria is present in insular sclerosis. It is probable, of course, that the figures would be quite different in a hospital for nervous diseases only.

2. I will now come to the second reason which I give for the interest of insular sclerosis—viz., that the diversity of the symptoms may bring it under the notice of anyone, whatever branch of medicine he practices, so that all ought to be alive to the significance of the early symptoms or they will be liable to make serious mistakes. It is unnecessary to describe the chief symptoms of the disease as given in Charcot's classical picture, now some 35 years old; you are all of you familiar with the spastic gait, the tremor (much increased by exertion), the scanning or jerky speech, the nystagmus, &c., which go to make up the symptoms of the fully established disease; but, great as is our debt to Charcot in this as in other matters for having separated the disease from the neurological mud heap, it is none the less somewhat of a misfortune that we were most of us brought up on that classical picture and therefore may fail to recognise the disease in its more irregular forms as we know it to-day.

If we waited to make a diagnosis of insular sclerosis until the patient had all the symptoms which I have enumerated we should make it but seldom and we must be content if we get one or two of these symptoms to confirm a diagnosis made partially on other grounds. Nor need I detain you with a discussion of the pathology of the disease or the disputed question as to whether the morbid change begins primarily in the vascular, nervous, or interstitial tissue. Whichever it be the result is the same—viz., the formation of islets of sclerosis of a peculiar character in various parts of the brain and spinal cord. The important point for us as regards the diversity of symptoms is this, that though there are certain seats of election where the change most commonly commences, the distribution is, speaking generally, a random one and therefore the initial symptoms may be of almost any character. As a matter of fact the majority of cases begin in one of two or three different ways. Most patients go first to the physician complaining of weakness in the legs, or of one side, or one limb, or of nervousness and trembling, but a considerable proportion go first (as is also the case with tabes) to the ophthalmic surgeon, often at a date considerably anterior to the appearance of any general symptoms. This point should always be inquired into, as the patients themselves do not connect the eye symptoms, which are usually of a transitory character at first, with the general disease and with the poorer class of patients they are often altogether neglected and probably forgotten.

I have appended a partial analysis of the 16 cases on which this paper is mainly based, which shows, so far as I have

[1] A paper read before the East Sussex Branch of the British Medical Association.

TABLE GIVING PARTICULARS OF 16 CASES OF INSULAR SCLEROSIS.

No.	Sex.	Primary symptoms.	Secondary.	Age at onset.	Causation.	Duration at first visit.	Sphincters.	Optic disc.
1	M.	Weakness of leg and arm.	—	37	? Syphilis.	6 months.	Yes.	*Nil.*
2	F.	Pain in right arm and knee; 9 weeks' loss of power in left hand and foot.	1 month later failure of sight in right eye.	30	*Nil.*	4 ,,	,,	,,
3	F.	Ophthalmoplegia externa; suddenly disappeared in 4 months.	Sudden attacks of loss of power in legs.	44	Worry.	2 years.	,,	Marked pallor.
4	F.	Weakness of legs; right first recovered and relapsed.	—	26	Pregnancy.	3 months.	,,	*Nil.*
5	M.	3 years before stiffness of the left leg and foot.	18 months of failure of right eye.	21	*Nil.*	3 years.	,,	Some pallor.
6	F.	Trembling and weakness.	—	20	,,	6 weeks.	No.	—
7	F.	Weakness of legs and tremors.	—	About 30.	? Syphilis.	5 years.	Yes.	Pallor of discs.
8	M.	Stiffness of left leg.	Tremor of speech and weakness of the left arm.	22	Blow over the right motor region.	3 months.	,,	(?)
9	M.	17 years' weakness of legs.	7 years previously diplopia and again 4 months previously.	23	Syphilis.	17 years.	,,	*Nil.*
10	M.	6 months very shaky.	—	47	Lifting very heavy weights.	6 months.	(?)	(?)
11	F.	6 weeks' weakness of legs.	—	11	*Nil.*	,,	Slight.	*Nil.*
12	F.	10 years previously severe vomiting lasted 3 weeks; diplopia; anæsthesia of the right side.	After diphtheria weakness of right leg.	35	Anxiety and diphtheria.	10 years.	Yes.	Pallor.
13	F.	10 years previously sudden loss of vision, returning gradually after a few hours.	4 years ago weakness of legs.	39	Anxiety and chill.	,,	Slight.	,,
14	F.	2 years before weakness of legs.	—	21	Malarial fever; abortion.	2 years.	Yes.	Yes.
15	F.	3 months before failure of vision in left eye, returning in 24 hours.	Tinnitus like bell booming.	30	Shock and diphtheria.	3 months.	,,	Slight pallor.
16	M.	6 years previously sudden fall in the street.	Diplopia.	69	Anxiety and hard work.	6 years.	,,	?

Note.—Case 11 eventually turned out to be a case of spinal caries.

been able to make out, what the early symptoms are. Of the 16, then, three began with purely ocular symptoms—viz., Case 13, in which the ocular symptoms antedated the others by six years; Case 3, in which they preceded by two years; and Case 15, in which they were three months prior. Besides these diplopia accompanied the earliest symptoms in Case 12, which were rather of a complicated character and suggested hysteria. In four other cases the ocular symptoms were the next to appear at intervals of one month, 18 months, and ten years after the first trouble, the date in the fourth case being unknown. The three cases in which the ocular symptoms came first were all seen in private and had all consulted ophthalmic surgeons who have been kind enough to give me their notes. I should add that in no case was the true nature of the disease suspected by anyone until some time after the appearance of the eye symptoms. In all the other cases the first symptom of the disease was some form of loss of power or disturbance of sensation, chiefly the former, in one of the limbs or both legs, generally of a transitory character and at first rapidly recovered from. One, Case 13, began with an attack of vomiting (amongst other symptoms), analogous, as Charcot long ago pointed out, to the visceral crises of tabes. As regards other symptoms it may be noted that the sphincters were affected to some extent in a very large proportion of cases, often quite early.

There is one symptom which I have never seen noticed anywhere but which has been so frequent in my female cases that I cannot help thinking it to be a result of the disease—viz., menorrhagia. In one the hæmorrhage was terrific at two or three periods, soaking the bed, and in at least four others it was severe. It is *a priori* probable that a disease which so often affects the lumbar centres should have some effect on the uterine functions. In this event a patient may consult a gynæcologist first, as I believe actually happened in one of my cases, No. 14.

In one of the cases above mentioned in which the patient first consulted an ophthalmic surgeon the next symptom that appeared was persistent and very distressing tinnitus for which she came to consult me. Finding nothing wrong with the ears and as no drug seemed to do any good I sent her on to an aural surgeon who reported that it was probably of nervous origin. I mention this because, though tinnitus is a rare symptom, it might easily be the first to appear and the patient might go in the first instance to an aural surgeon. Again, aphonia may be an early symptom and the patient may consult a laryngologist for loss of voice. Lastly, a patient may consult a surgeon for supposed injury to the spine or for some bladder trouble, though this rarely appears till later in the course of the disease. In one case, of which I shall give you more details presently, as being a very typical case of slow hysterical onset, the patient was for some years under a surgeon for various hysterical phenomena, beginning with contracture simulating talipes equino-varus.

Of course it is very difficult to say at what time the existence of the disease might have been recognised in these various cases; as a rule it is not even suspected and I must own that in the case of the female who came to me for tinnitus it was some time before I recognised the real nature of the trouble, and then only because there was difficulty in walking. The total duration of the disease in this instance was only nine months. It is clear, I think, from what I have said that it is necessary for us to examine with some care those cases in which there is temporary loss of sight in one or both eyes, or diplopia, or transient aphonia, or difficulty in walking, or sudden falls without any apparent cause to account for them, the patients as a rule complaining that their legs suddenly give way. We must not put them aside as merely hysterical because they are associated with a highly emotional manner or with other symptoms which are usually regarded as hysterical. The truth is (as Dr. T. Buzzard, who has done more than anyone else to elucidate the relations between hysteria and insular sclerosis, has pointed out) that some of the very symptoms which formerly were regarded as typical of hysteria should now arouse our suspicions and lead us to think that in all probability the case is not one of hysteria, especially those symptoms connected with the eyes.

3. This leads me on to my third reason for insisting on the

importance of insular sclerosis—viz., the difficulty of diagnosis and the confusion with hysteria. It is, in fact, this liability which makes the diagnosis of insular sclerosis of such great importance. As regards treatment by drugs and other measures, unfortunately it cannot be said that we can do much, but on the other hand we do a good deal of harm to the patients by treating them as hysterical and insisting on constant effort, and by exposing them perhaps to the reproaches or ridicule of their family, on the ground that they could easily do things if they would only attempt them.

The most misleading thing about the early stage of the disease is the transitory nature of the symptoms; it is this which is really typical. The patients can see one day and be almost blind the next, or they can walk fairly well one moment and the next be unable to move from their beds. The symptoms may come on with startling suddenness and depart almost equally suddenly. It is not surprising that symptoms which seem to be so entirely capricious in their coming and going should be thought to be hysterical, for it is difficult to explain them on the theory of any organic lesion and I do not know that any adequate explanation has yet been given. But it is quite certain that an organic lesion exists; if the progress of the case be watched the symptoms which were once transitory become more or less permanent, the vision gradually becomes worse and worse, and the optic nerve, which at first showed slight pallor, may become entirely atrophied. The difficulty in walking persists and leads to contracture, the tremor which used to be intermittent remains constant when anything is attempted and makes all occupation impossible. There is no longer any question of our having to do merely with some functional disturbance and if the case goes to a fatal termination we are certain of finding the characteristic lesion in the brain and spinal cord, save in very rare instances.

There is another thing which adds considerably to the difficulty of diagnosis—viz., that many of these patients have what we are pleased to call a typically hysterical manner—i.e., they are very emotional and easily moved to tears or laughter and the voice may have that tremor which is often found in highly nervous people, but here may be a symptom of the disease. This is by no means the case with all but it is so with not a few and adds considerably to the probability that the case will be regarded as hysterical.

Dr. Buzzard has pointed out the chief criteria on which we must rely for a differential diagnosis and as I cannot improve on his account I will merely recapitulate what he says. Of course, there is no difficulty in a fully-developed case of the disease in which the tremor, so-called scanning speech, both much accentuated by effort, the spastic gait, increased reflexes, nystagmus, &c., are all present, but it may be years between the first appearance of the disease and the establishment of conclusive symptoms of this kind, and meanwhile the diagnosis will hang in the balance, sometimes inclining to hysteria and sometimes inclining to organic disease, according as the various symptoms are active or remittent at the time. In Dr. Buzzard's words: "Until such symptoms as the above make their appearance in a case about which doubt has existed I do not think that we can as a rule safely pronounce a diagnosis of insular sclerosis. But in a case in the history of which paresis has occurred in one or more limbs with spontaneous recovery and repeated recurrence of the symptoms in the same or another part, together with a history of amblyopia either temporary or persistent, my experience would lead me to diagnose insular sclerosis in the absence even of the symptoms first enumerated."

There is one reflex symptom to which Dr. Buzzard draws attention in a later paper and about which I should like to say a few words, because it is sometimes present when all the others are inconclusive and is almost, if not absolutely, conclusive evidence of organic disease of some kind—i.e., the "toe phenomenon." When the sole is stimulated the normal response is, except in infants who have not walked, flexion of the toes on the foot at the metatarso-phalangeal joint; in pathological conditions, where the fibres of the pyramidal tract are involved at any point, this flexion is replaced by extension of the toes, especially of the great toe. Babinsky, who discovered it, never found it except in cases of organic lesion, and Dr. Buzzard confirms this. I have tried it in a very large number of cases and never found it present where organic disease of the nervous system was unsuspected except once in a case of diabetes, where it may possibly have existed unsuspected. It must be added, however, that its absence proves nothing and that it is uncertain in its appearance, being present at one time and not at another. It has never been known to occur in any case of purely functional disease and is therefore a very valuable symptom in the diagnosis of hysteria, the most valuable of all the reflex symptoms.

I will now give you an account of one or two cases beginning with one which is a very good example of the difficulty of diagnosing between hysteria and insular sclerosis and, in fact, leads one to wonder where the one ends and the other begins.

CASE 7.—The patient, a woman, aged now 39 years, has been several times in the Sussex County Hospital, besides one or two London hospitals, and was always regarded as a hysterical patient. As far back as 1878 she was under the care of Mr. W. Furner for contracture simulating talipes equino-varus. Under chloroform this disappeared but reappeared on her return to consciousness. When this leg was put up in plaster the deformity appeared next day in the other leg. At another time she was taken in for a superficial ulcer on the abdomen which was almost certainly caused by some injury she herself had inflicted, probably with acid. She was also admitted at other periods for various ailments which were always regarded as hysterical. I saw her first some two years ago, some five years since her last visit to hospital, and came to the conclusion that she was suffering from insular sclerosis; a fortnight ago I again saw her, a typical example of the last stage of insular sclerosis—bedridden and with excessive tremor, complete loss of sphincter control, and with those mental changes which are often found in that disease. The chief points about this case are briefly these: 1. Its very long duration. 2. The fact that the first symptoms of organic disease were preceded by symptoms which are universally regarded as functional in their character and which undoubtedly occur in hysterical persons who never show any signs of organic disease and are proved by post-mortem evidence to be free from it. There was, therefore, every reason to believe that the case was hysterical and that the weakness of the legs for which I first saw her was an hysterical paraplegia, but with this there were incontinence of urine and an amount of tremor, with ocular symptoms, which made it impossible to regard the case as functional. At the present moment, three years after, her condition is, as I have said, quite unmistakeable. We must conclude, therefore, that this was a case in which true hysteria, characterised not only by the physical phenomena but by that psychical condition which leads people to inflict injuries on themselves, preceded insular sclerosis.

Charcot mentions cases in which hysteria preceded the disease but does not say how many he saw; and it is clear from his classical account of it that he only recognised the disease in its established form and therefore probably did not lay much stress on the connexion with hysteria or the difficulty of diagnosis. It is important to distinguish between those cases in which undoubted symptoms of hysteria come first and those in which what are really symptoms of insular sclerosis are mistaken for hysterical troubles and only recognised subsequently as the prodromal symptoms of insular sclerosis. The latter is much more commonly the case. Some of these symptoms are such as are found at times in undoubtedly hysterical patients and these are now believed by the best authorities to be really indicative of insular sclerosis though not conclusive without other evidence. I will mention one or two cases of this character.

CASE 13.—The patient, a woman, aged 48 years, had in 1886 an attack of sudden amblyopia which passed off completely in 24 hours in the left eye but affected the right for several days. In 1892 after exposure to cold she began to suffer from weakness of the legs which had increased slowly and difficulty of vision which was very variable. She also showed some mental changes, becoming irritable, suspicious, and forgetful. Her case had progressed very slowly and she was still able to get about but the ocular symptoms and condition of the reflexes with some loss of sphincter control left no doubt that the case was really one of insular sclerosis with very slow hysterical onset. This case was one with rather unusual onset; the anæsthesia and vomiting were regarded as hysterical and subsequent events alone have shown their true significance. In this case, too, the disease has made very slow progress and several of the classical symptoms are still absent but no reasonable doubt can exist as to the nature of the trouble.

One word as to causation. In many cases no cause can be assigned but anxiety, hard work, and, in Case 10, severe physical exertion seemed to be potent factors. Case 8 is interesting in that the symptoms seemed to follow directly on a blow, the scar of which could be felt over the right motor region and commenced first in the left leg. In this case the disease progressed very rapidly and in three months showed most of the typical symptoms. Diphtheria in two cases and malarial fever in another seemed to be to some extent responsible at least for an aggravation of the disease and pregnancy, as in Case 4, is well known to be injurious.

In conclusion, gentlemen, I must ask you to excuse me for the inadequacy of this paper, but I hope that I have said enough to show you that the subject is not a barren one and that it is of real importance in cases which appear to be hysterical at least to have a suspicion that they may have an organic basis. I hope, too, that I have shown you that it is a disease of which everyone ought to have some knowledge whatever his branch of medicine and be able to recognise the symptoms from his own point of view as at all events suggestive. We do not as yet know how early it is possible to recognise the disease because it is as a rule difficult to get back to the beginnings of it. It is just in this matter that we are able to do something to assist the nerve specialist because we often see cases over prolonged periods which he only sees rarely and the earliest symptoms usually come under our notice rather than that of the specialist.

If we are ever to do anything to combat this formidable disease, which is very possibly increasing in frequency with the general increase of nervous strain, to which in some instances it is undoubtedly due, we must take it at its commencement and to do that we must learn as much as possible about its earliest symptoms. I would therefore appeal to all those who may have the opportunity to make as accurate a study as possible of the cases which they may come across and especially to note and to report any with abnormal onsets or in which the causation seems particularly clear. Nervous diseases, largely on account of their hopelessness, are not a very tempting study to the man who is not a specialist, but most valuable aid in the elucidation of disease may be rendered by him and to him in the end the specialist must look for much of the most essential information about the history of cases such as those of insular sclerosis.

Postscript (1905).—Of the cases mentioned three are dead—viz., 14, 15, and 16—but all were private cases and in no case was a necropsy obtainable. Of the others Case 11 subsequently developed spinal caries, though she had no symptoms of it at the time and was shown two months later at a London hospital as a case of spastic paraplegia. Of the remainder nearly all have been seen subsequently, especially Cases 2, 3, 4, 5, 7, 12, and 13. In all the course of the disease has confirmed the original diagnosis but it is interesting to note that the prognosis both as to duration of life and to recovery from mental and physical symptoms has been repeatedly falsified. Case 7 who seemed to be in the last stage of mental and bodily decrepitude, is still alive and sufficiently recovered to recognise me at my last visit and to converse rationally. Case 3 is practically bedridden but quite clear in mind, though emotional; she can hardly use her arms owing to tremors and her eyesight is very bad. Case 12 can get out occasionally, though for a time she seemed absolutely helpless; she is emotional and irritable but quite clear in the head and can use her hands perfectly as a rule, writing quite legibly, and her eyesight is very fair.

Two points seem to be clear: 1. That the slower the onset of symptoms the more hopeful is the prognosis as to remissions and the less likely is any given attack to be finally crippling to mind or body. 2. The fact that the earliest symptoms are cerebral does not necessarily imply that those will be specially predominant later; in both the last cases ocular symptoms came first but the brain and upper cord are comparatively little affected, whilst the paraplegic symptoms have been prominent for some years.

Brighton.

VACCINATION GRANT.—Mr. John J. Huey, L.S.A., public vaccinator of the Mexborough, Adwick, and Bamboro' districts of the Doncaster union, has received the Government grant for successful vaccination.

SABOURAUD'S METHOD OF RINGWORM TREATMENT.

BY J. L. BUNCH, M.D. LOND., M.R.C.P. LOND.

UNTIL quite recently the treatment of ringworm has been tedious, trying, and uncertain. Many medicaments and chemical substances have been vaunted as cures; lotions, ointments, and sprays of various nature have been brought forward as infallible, but the fungus has shown itself to be possessed of an extraordinary amount of resistance when once it has invaded the hair of the scalp. The difficulty of the problem depends on the fact that most of these chemical substances and all antiseptics are capable of killing the ringworm and all other cryptogamic parasites *in vitro*, but no antiseptic can penetrate the hair follicle to a greater depth than one millimetre. The hair of a child, however, is implanted in the skin up to a depth of four millimetres, and the parasite of ringworm involves its root down to the terminal enlargement of the hair bulb. The parasite of favus is similar in that it also is inaccessible to antiseptics, but the disease can be successfully treated by five or six epilations repeated at intervals of a month. This method, practicable in favus because the hair remains solid, is impracticable in ringworm because the affected hair becomes fragile and breaks. It cannot be pulled out entire but breaks at its most diseased portion and the fungus spores remain behind with the root. The hair continues to grow but the parasite continues to develop in proportion to the growth of the hair.

The parasite of ringworm is not always the same and from the point of view of treatment by chemical agents[1] a considerable degree of importance attaches to the variety of fungus which is causing the disease. In England the great majority of cases are caused by the microsporon Audouini—in Fox and Blaxall's cases from 80 to 90 per cent., other observers giving 80 to 96 per cent.—whereas in Paris the microsporon only causes 60 to 70 per cent. of the ringworm cases. In the large spored variety the distribution of the ectothrix and endothrix varieties differs, Sabouraud, for instance, having published a series of Paris cases in which the megalosporon ectothrix was absent in all the scalp cases, although it was found to be the cause of all the cases of ringworm of the beard. In a series of cases published by myself[2] the origin of certain cases of ringworm from animals was proved and in these cases the megalosporon variety was found to be much the more common. Little importance attaches from the point of view of treatment to the question whether the epidermis is attacked before the hairs or *vice versâ*, although my investigations have shown the former to be the case; much more importance attaches to the nature of the fungus. Thus the microsporon is much more resistant to treatment than the megalosporon, some cases in children being so obstinate that they persist, in spite of the most active treatment, till puberty and then the disease disappears for some unknown reason, and in any case we cannot fix a limit within which a cure may certainly be effected.[3]

Such, then, being the result of treatment by chemical substances and the root of the hair being inaccessible to antiseptics, the solution of the problem could only be found by discovering an agent which was capable of inhibiting for a time the function of the papilla from which the hair grows. Such an agent is radiotherapy. During the last few years immense improvements have been effected in the technique and methods of application of radiotherapeutics, but it has been well known for some years that the application of the x rays causes the hairs to fall out, and in 1896, one year after Roentgen's discovery, Freund attempted the treatment of ringworm and various forms of dermatosis by radiotherapy. Since then numerous attempts have been made to establish a definite method of treatment of cases of ringworm but the absence of satisfactory methods of measuring the radiations employed and the resulting accidents have made many experimenters timorous. Moreover, the large number of exposures necessary (as many as 40 have been quoted for a single case) made the treatment of

[1] This does not include the x rays.

[2] Bunch: On Ringworm Infection in Man and Animals, Brit. Med. Jour., vol. i., 1901, p. 323.

[3] Allan Jamieson: Edin. Med. Jour., June, 1900, p. 547.

ringworm by radiotherapy of no practical value. The unsuccessful results were all due to the same cause—uncertain dosage of the rays owing to an absence of measurement or imperfect measurement of the quality and quantity of the rays applied to the diseased area. Of these two measurements that of quantity is more important than that of quality, inasmuch as the therapeutic reaction depends essentially on the quantity of rays absorbed. Other factors undoubtedly enter into the calculation, such as the age of the patient, the position of the cutaneous area to be treated, the nature and the degree of the lesion, to say nothing of idiosyncrasy, but these biological factors are of minor importance as compared with the physical factor of the quantity of rays absorbed. In England the possibilities of radiotherapy as applied to the treatment of ringworm have not been grasped because no satisfactory attempt has been made to measure the dosage of the rays or to proportion to each case the exact amount of therapeutic agent necessary. Measurement of the current supplied to the tube by means of an ampèremeter is not sufficient; the rays generated by a tube vary from time to time according to surrounding conditions and according to the internal conditions of the tube—whether it is hard or soft, new or old. The variations in production of two different tubes at different times may naturally be still greater, and the chances of obtaining the same results with two different installations or at different times are almost minimal if we do not know exactly in each case the quality and the quantity of the rays absorbed. The dose must be proportioned to the disease. This rule applies to other diseases besides ringworm, and where more than one séance is necessary one should adopt Béclère's rule of causing to be absorbed at each séance the maximum quantity of rays compatible with integrity of the integument, and interpose between the different séances the minimum interval of time compatible with integrity of the integument. Neoplasms and many other cutaneous lesions must be treated thus, but ringworm offers a simple problem inasmuch as the patients are more or less of a similar age, the lesions are situated on similar areas of the scalp and are the same in character and in depth. The dose, too, necessary for successful treatment is less than that which will cause a radio-dermatitis, so that it can be administered at a single séance, which is of course a great advantage when dealing with children.

The amount of dose necessary for the successful treatment of ringworm has been worked out by Sabouraud at the Hôpital Saint-Louis with the greatest care, and from personal observation covering several months I can assert that his treatment is simple and extremely effective. The number of successful cases which I have seen is not only very considerable, but the relative proportion of successful to only partly successful or unsuccessful cases is certainly high. Sabouraud has himself published results of treatment which show how greatly superior this method is in his hands to all the methods which he has employed before, and his description of this method and his conclusions are included in this paper. The method is painless, the actual time necessary for the treatment is short, and the diseased hairs fall out at a definite interval after application of the x rays and are replaced after a certain time by a growth of healthy hair.

The essential apparatus necessary is an electric current, constant or alternating, and a Crookes tube. The electric energy for the production of the x rays can be derived from a static machine, a Ruhmkorff coil or a transformer, and the Crookes tube can be of almost any pattern or any age. Sabouraud uses a static machine of ten plates driven by a three-quarter horse-power dynamo[4] with a Béclère "spintermetre" interposed between it and the tube. This latter modification warns the operator at any moment of an increase in resistance of the tube and enables him to make any necessary alterations. The tube has an ingenious modification of Villars which enables it to be made "soft" at will. To a lateral branch of the tube is attached the open end of a tube of platinum, the other end of which is closed. When the resistance of the tube increases this tube of platinum is warmed by a Bunsen burner, gets red, becomes porous, and allows a little of the hydrogen of the flame to enter the tube. If the tube contains too much hydrogen or is getting old (after about 50 hours of work) a second platinum tube of larger bore should be placed loosely round the first and heated; the tube will become very "hard" again. In practice to render the tube which is being employed harder at will there is interposed a lateral derivation of the current—a resistance. The relative hardness or softness of the tube is recorded by the radiochromometer of Benoist, and in practice it is found that the resistance of the tube should correspond to the fourth division of the scale.

Thus, by means of the accessory apparatus we know at any moment what is the degree of penetration of the x rays produced by the tube and are warned as soon as this changes and can immediately make the necessary alterations. Only one measurement is still wanting. It is that of the *quantity* of the x rays generated by the apparatus in a given time. To measure this Holzknecht's pastilles have been employed. These are composed of a mixture of alkaline salts and resin which slowly change in colour under the influence of the x rays. One is placed in the path of the rays at a distance equal to that of the patient's skin. From time to time the change in colour is compared to the standard scale, each of the 12 degrees of which is termed by Holzknecht *one unity H*. Experience shows that the tint corresponding to 5 unities H on the scale must not be passed, at least at one sitting. But these pastilles, although excellent, are a secret preparation and consequently are expensive. To use them on a large scale would be a costly matter and Sabouraud has recently adopted the use of paper covered with an emulsion of platino-cyanide of barium, which is cheap and can be employed several times. It changes in tint when exposed to the rays and the tint which corresponds to five unities H is found and copied in water-colour and kept at hand for reference when working. It has an advantage over the pastilles in that it does not become darker when withdrawn from the rays, while the pastilles do, and that it regains its original colour again when removed from the rays and exposed to the light. It is less sensitive, however, than the pastilles to the x rays and for estimations must be placed at about half the distance of the pastilles from the anticathode.[5] This must be borne in mind but does not otherwise create any difficulty.

From the preceding the following rule is deduced. To cure a patch of ringworm it must be exposed at a distance of 15 centimetres from the Crookes-Villars tube, the tube having a resistance corresponding to the fourth division of the radio-chromometer of Benoist, until the quantity of the x rays generated amounts to four and a half or five unities H of Holzknecht's scale. By keeping to the above rule we can obtain a depilation pure and simple of the portion of scalp desired without complication of burns either trivial or grave—in a word, without accidents. The operator and the healthy portions of the patient's scalp must be protected from the rays by inclosing the tube in an impermeable sheath perforated by apertures, one of which admits a metal tube corresponding to the size of the ringworm patch on the scalp. A scalp treated in this way shows no immediate result. Towards the seventh day a scarcely perceptible erythema appears on the area which has been exposed to the rays but it may sometimes escape observation if it be not carefully looked for. This erythema disappears after three or four days and is replaced by a pigmentation so little marked that it is necessary to search for it. From the fifteenth day onwards the hairs fall out over all the area treated without any effort of traction and in a few days depilation is complete. The extruded hairs are less glistening than normal and patients say that they look as if they had been scorched. The hairs fall out because of the action of the rays on the hair papillæ, the function of which is paralysed for a time, but for a time only. The old hair has been extruded by the time the new hair begins to grow but even when the new hair rapidly succeeds the old the two remain separated as a rule by a complete thickness of interposed epidermis.

Thus it is possible that a hair which contains a parasite localised to the horny epithelium can be eliminated outside the skin by a physiological process without the new hair which is growing below being contaminated. It is fortunate that this is so, for the action of the x rays is not fatal to the ringworm parasite and cultures made from the remnants of hairs in process of expulsion are still positive. Re-infection of the scalp is, therefore, easy and the greatest care is necessary to prevent such inoculation.

The growth of the new hairs is slow. This is one of the inconveniences of the method but also one of the reasons of

[4] Vide Bunch: Sabouraud's Treatment of Ringworm by X Rays, British Journal of Dermatology, July, 1904.

[5] 3·1 inches as compared with 5·9.

its success. The last débris of the diseased hair has long been extruded when the new hairs appear. The new growth as a rule becomes visible in the course of the seventh week after depilation, the tenth week after operation. Its date is a little variable but it never fails and hardly ever is later than 12 weeks after exposure to the x rays. The growth is always slow; in normal cases it is almost complete two months after its commencement. The treatment of a single patch of ringworm is simple. A single sitting is sufficient and the danger of re-infection or recurrence is minimal, but where a large proportion of the scalp is affected or there are numerous small lesions scattered over it a certain degree of difficulty arises. For to act upon all the upper surface of the scalp the tube would have to be placed some way off and as the time of exposure necessary increases as the square of the distance the immobility of a child could not be secured for a sufficient length of time. Moreover, oblique rays are weaker and less depilatory than vertical rays and they frequently lead to the development of pustular lesions round the irradiated area, no doubt owing to the staphylococci which are always present on the scalp ready to develop on any region which has undergone injury. Sabouraud goes further and states that oblique rays have a specific injurious action. Oblique rays should, therefore, be eliminated and where a large area of scalp has to be treated this is best done by dividing it up into several smaller square areas and treating each of them separately. Square areas are much more practicable than round, avoiding overlapping or the omission of small triangular patches where two or three circular areas adjoin, and they can easily be managed either by modifying the shape of the screen tubes or by inserting into the distal ends of the tubes diaphragms of lead in which square holes have been cut. The functional aperture of the screen tube is therefore now square, the areas which are treated can easily be mapped out, and no overlapping need occur at their lines of juncture.

Sabouraud has had six cases of x ray dermatitis in 2000 séances and these happened before estimation of the quantity of rays emitted by a tube in a given time was possible. In estimating this quantity it must always be remembered that it is much more dangerous to work with rays marking about 10° on the radio-chromometer than with those marking about 4°, since in the former case the rays are not only more penetrating but also more numerous. This has a bearing on the way in which tubes are to be employed. It has been pointed out that a Crookes tube after ten hours of service becomes coloured violet in the part exposed to the action of the x rays and after 30 hours this area begins to look smoky. This latter change is accompanied by a modification of the properties of the tube, in that it becomes more and more difficult to obtain from it the non-penetrating rays equivalent to 3°–4° on the radio-chromometer; when the attempt is made the tube does not illuminate properly and the anticathode hardly reddens, although from the same tube rays corresponding to 8°–10° can be obtained perfectly. These latter rays are equally capable of causing the hair to be shed, but when employing them it must be remembered that more rays are being employed in the same time and that the time necessary for depilation will only be half that necessary when rays corresponding to 4°–5° on the scale are made use of. But if this be remembered and the dosage accurately proportioned the effective life of the tube can be lengthened from about 60 to 150 hours. If, on the other hand, the dosage is inaccurate and the rays marking 8°–10° be continued for the half-hour necessary when rays equal to only 4° are used a well-marked dermatitis will occur about the tenth or twelfth day which at the best will not be more than an erythema and will disappear in a week. Even in this case, however, it will cause an alopecia lasting three or four months. If a more definite burn be produced the alopecia will inevitably be total, lasting, and complete.

Attention must also be paid to the danger of using too small a dose and having to repeat the dose. The first séance, if insufficient, will cause an imperfect fall of hair and if a second séance be given those hairs which survived the first time will fall out, but those which fell out as a result of the first treatment will not grow again. The possibility of such an alopecia resulting must be borne in mind and especially when there is a likelihood of two adjacent areas overlapping during treatment must it be remembered that such overlapping may cause a burn if the doses are maximal, even if an interval of several days be interposed between the applications of the rays. Such accidents can only be avoided by accurate measurement of the quantity of rays absorbed by the skin and accurate dosage but given satisfactory radiometry Sabouraud states that the recurrence of these accidents is impossible. Any want of success is due to other causes, such as restlessness of the child or forgetfulness on the part of the operator leaving an island of hairs which are difficult to see and which show up when the disease is cured everywhere else. Or there may be insufficient depilations at one or two points, leaving several diseased hairs which do not fall out, or reinoculation may take place during the course of treatment. But in spite of these possibilities the results are good. Before the time of radiotherapeutic treatment the average length of treatment of ringworm at the Saint-Louis Hospital was 18 months; now it is three and a half months. During the first six months of 1903 only 57 children were cured in the ringworm schools; during the first six months of 1904, 134 children were cured in the same schools; and among the cases successfully treated by the x rays were included over 100 which had resisted all other treatments. Such results have not been obtained in any other country and cannot be obtained by any other method of treatment. Moreover, these results could be considerably improved upon, even with the same apparatus and the same staff, if the children after having undergone x ray treatment were only kept in the ringworm schools until the hair had fallen out and then sent into the country until the new hair had grown. They would be non-infectious and would require only the most cursory medical supervision. When once the new crop of hair had grown again no trace of the disease would remain. In this way a large number of cases of ringworm could be cured in a short time at small cost and return to their ordinary school routine without the slightest danger of infecting other children.

Margaret-street, W.

SOME CASES OF URETHRAL STRICTURE COMPLICATED WITH A PROSTATIC FALSE ROUTE OR PASSAGE; WITH REMARKS.

BY REGINALD HARRISON, F.R.C.S. ENG.,

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THE records of surgery furnish some remarkable instances of this somewhat rare lesion where persons suffering from it have for some time led a more or less active life. I will take some illustrations of it connected with strictures in the deep urethra.

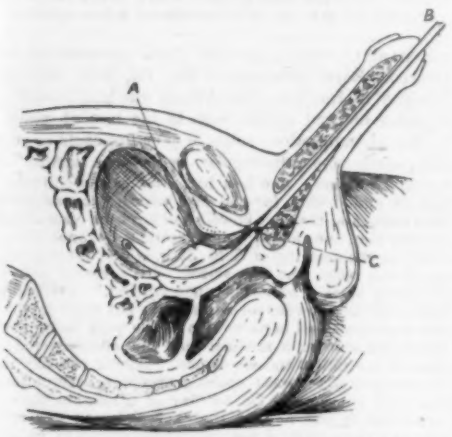
Some years ago a man was landed from a sailing ship in the following circumstances. He was a sailor, aged 40 years, and had suffered for many years from stricture. Three months before I saw him when at sea he broke his small elastic catheter in attempting to relieve an urgent attack of retention of urine. A silver instrument of a larger size was then passed for him by the captain of the ship with much force, pain, and bleeding. This process was subsequently repeated on several occasions during the voyage and the instrument was frequently retained for some hours at a time. In the course of some weeks the man passed urine voluntarily in sufficient amount to keep himself comfortable and he was able to get about the ship but not to do duty. His general health, however, began to fail and on his arrival in port he was far advanced in renal disease. I passed a catheter for him but it was obvious that the instrument did not take a natural course, though several ounces of foul urine were withdrawn by it. The line of the catheter could be distinctly traced with the finger in the rectum. He died shortly after his arrival and a necropsy was made. There was a dense stricture in the deep urethra which would only admit a bristle and beneath it was a false passage through the prostate (which was not enlarged) one and a half inches in length which opened into the bladder above the gland and had done duty fairly well for the prostatic urethra.

For the two following cases I am indebted to my old friend the late Mr. W. Cadge of Norwich, whose work in connexion with stone and urinary disorders is so well known and appreciated. Mr. Cadge wrote to me in regard to the first: "This was a case where I made a post-mortem examination and the specimen is now in our hospital museum.

It was that of a man with a chronic stricture and perineal fistula, where a silver catheter had been forced in by a surgeon and the passage gradually dilated up to No. 12 (English). The patient wore day and night a soft rubber catheter and he died after a few years of renal disease. After death it was found that the catheter had left the urethra at the front end of the stricture and had tunnelled a new passage through the prostate alongside the proper urethra. I found an epithelial growth on the bladder where the catheter had rested and the false passage was lined with a smooth, shining membrane and answered the purpose of a catheter fairly well."

The other case was that of a man with an old stricture where a false passage had also been previously made. Mr. Cadge wrote: "I used to pass a No. 8 or 9 through the false passage but I felt sure it was a false passage and as he lived a long way from Norwich I put him in the hands of another surgeon nearer him who, with much care and pains, got in a minute soft catheter through the stricture, kept it in, and in a fortnight he was able to use No. 12 flexible and the patient, I believe, has never had any trouble since." Mr. Cadge further remarks: "So far as my experience goes there is always one sign of a false passage present—viz., when a large catheter is passed and removed the false passage quickly or almost at once collapses and the patient cannot pass urine much better than before any instrument was used."

These two narratives were sent to me by Mr. Cadge in response to the written particulars of the following case about which I was desirous of hearing from him. It was that of a middle-aged man whom I saw some time ago and who had an old tight traumatic or scar stricture and a false passage beneath it from the bulbo-membranous urethra tunnelling the floor of the prostate and so entering his bladder through the trigone. The lesion or false route seemed to correspond with the first case described in this paper of which I made a drawing (see illustration).



A, The prostate gland. B, Catheter, leaving the urethra in front of the stricture, passing through the prostate and entering the bladder. C, Entrance of the stricture.

For some time treatment had consisted in what was supposed to be dilatation of the stricture by the passing of metal bougies. Later I was asked to see this patient and I also repeated this process but with the feeling that there was something wrong in the direction of the instrument. Subsequently with a set of filiform bougies and fine "whips" I hit off the way through a long stricture immediately in front of the prostate and entered the bladder naturally. It was clear then that there were two ways to the bladder through the prostate, one by the natural course guarded by a very contracted stricture, and another which had been artificially made, so to speak, for occasions of great and recurring urgency. How to close the one and to open the other was the point to determine. The stricture was much too scar-like and contractile to yield to dilatation, continuous or otherwise. Guided by some experience in similar cases it appeared to me that this would be best secured by the combined operation of internal and external urethrotomy.[1] This was effected in the following manner, which was planned to avoid adding unnecessarily to the amount of scar tissue in relation with the urethra. By using a fine Holt's dilator introduced on a filiform guide the stricture was stretched so as to permit of a Maisonneuve's urethrotome being passed by which the contraction was divided. In this way I at once enlarged the very contracted urethra sufficiently to enable me to introduce a fair-sized median grooved staff into the bladder. Upon this a perineal section was performed and one of my full-sized gum elastic drainage-tubes was put into the bladder along what had been for some years a closely contracted and unused half inch or so of urethra. The wound was closed with catgut sutures around the drainage-tube which was secured in the ordinary way. This patient made an excellent recovery and after many years' painful interruption again passes urine in a natural stream. He takes the precaution of occasionally using a bougie for himself.

In these cases where the deep urethra is involved in dense masses of cicatricial tissue, mainly the result of disease or injury, or both, and where perineal fistulæ are also present the combined operation is, I believe, the surest treatment. The possibility of such a complication existing as here described must not be entirely lost sight of in connexion with the symptoms presented in certain forms of deep urethral stricture. In the instances which have come under my observation it was found possible to demonstrate that the normal canal, though in an extremely contracted form, did exist. Further, the cases narrated tend to show that with care and patience it is possible to restore the dimensions of the natural canal by dilatation or otherwise even after long periods of disuse and also permanently to obliterate the false route or passage.

Lower Berkeley-street, W.

COLLES'S FRACTURE AND OTHER FRACTURES AND DISJUNCTIONS AT THE LOWER END OF THE RADIUS AND ULNA.[2]

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THE term Colles's fracture ought to be confined to those fractures of the radius close to the wrist-joint in which backward displacement of the lower fragment occurs. It has, however, been loosely applied to all fractures in the vicinity of the joint. The ordinary form of Colles's fracture is usually produced by falling on the hand in the three-quarters pronated position and not, as is commonly stated, in the fully pronated position. It is usually stated that the accident is most common in women of an advanced age. In the series of 69 cases 54 per cent. occurred between the ages of 30 and 50 years, and only 38 per cent. after 50 years. The largest number (17 cases) in any decade occurred between 30 and 40 years and 12 of these were males, although taking all the cases together the numbers were 28 males and 29 females. About 50 per cent. of the women were over 50 years of age, while only 25 per cent. of the men were over that age. In the men, therefore, 75 per cent. of the fractures occurred before 50 years. The side affected was noted in 47 cases: 27 fractures were on the left side and 20 were on the right side. In most of the cases the injury was situated within the last inch of the bone. The series of sections of bone sawn from side to side and from before backwards shows that the compact tissue ceases about one inch from the tip of the styloid process on the outer side and about three-eighths of an inch from its lower end on the inner side. Behind, the compact layer descends to within about half an inch of the joint and in front a line or two further down.

[1] THE LANCET, June 11th, 1898, p. 1611.

[2] Abstract of a paper read at a meeting of the Ulster Medical Society held on Feb. 2nd, 1905. It was based upon a series of 69 cases, of which 11 were disjunctions of the lower epiphysis of the radius. In illustration of his remarks, Mr. Fullerton showed a profusion of lantern pictures, skiagrams, ordinary photographs, museum specimens, and splints.

This accounts for the obliquity from above downwards and from without inwards, which is seen in a large number of the skiagrams. The presence of a spike of bone running up the shaft on the outer side is a marked feature in many cases. (Skiagrams were shown illustrating several unusual forms of fracture, including some of fracture of the radial styloid process alone extending into the joint on the inner side.) The ulna was implicated in over 50 per cent. of the cases. Skiagrams show that in fracture of the styloid process there is considerable variety among the results of treatment. In some this process unites again, in others it becomes thickened, in others it remains distinct, and in others it disappears altogether. In some of the cases fracture of the ulna at the same level as the fracture of the radius was found. Complete separation of the radius and the ulna with probable rupture of the triangular fibro-cartilage takes place in many cases. Fracture of the styloid process of the ulna alone may occur in injuries about the joint, as for instance, when the carpus is dislocated backwards.

The presence or absence of impaction was noted in 45 cases. In 12 there was marked impaction, two of these cases being fractures of both bones at the same level and in others there were probably some posterior impaction and some crushing of the fragments. In all these fractures a good result was obtained by manipulation and splints. Comminution as seen by skiagrams was present in five cases out of 47; it may have occurred in others but was not diagnosed either by skiagrams or by symptoms.

The displacement of the fragments and consequent deformity were carefully noted in all the cases and have been classified under the following three heads. 1. Those in which the lower radial fragment is displaced backwards, this being by far the most frequent form of the injury. 2. Those in which displacement of the lower fragment outwards is the most marked feature. In these cases the patient has probably fallen on the ulnar border of the hand. 3. Those in which forward displacement occurs, this being a very rare form of the injury. The description in text-books in which abduction of the hand is given as a sign of these fractures is open to great objection. In most cases the fingers are either in the normal position or are slightly flexed to the ulnar side, so that adduction of the fingers and radial displacement of the wrist would be a more suitable description. The cases in which there is narrowing of the interosseous space between the radius and ulna must be very rare; in several of those included in the series this space was actually widened in consequence of comminution of the lower fragment of the radius or separation of the radius from the ulna. In the cases with displacement to the radial side the wrist is broadened from side to side, suggesting a line of treatment different from that which is usually employed.

The complications that occurred in the series were as follows: fracture of the ulna at the same level, three cases; fracture of the styloid process of the ulna, 52 per cent.; rupture of the triangular fibro-cartilage allowing of separation of the radius from the ulna (comminution), five cases; injury to the median nerve, two cases; laceration of the tendon of the extensor secundi internodii pollicis by the ragged edge of the lower fragment, one case; fracture of the anatomical neck on the same side, one case; and fracture of a carpal bone (the scaphoid), one case.

In considering the treatment of these fractures it is essential to subdivide them according to the nature of the displacement. In dorsal displacement two splints ought to be applied, the anterior one not coming below the fracture and the posterior one being so padded that the hand is flexed to an angle of 45°. If there is impaction it must in all cases be first broken down, if possible, and the parts firmly pushed into position before the splints are applied. The recent suggestion that no attempt should be made to break down impaction or to employ splints is not to be recommended. The parts, however, ought not to be kept in splints for longer than a fortnight unless in very exceptional circumstances; the patients ought also to be visited every second day and encouraged to move their fingers. In the large majority of cases there was no stiffness of the wrist; when it occurs it is probably due to fracture into the joint or to injury of the carpal bones. In many instances the patients were able to return to their work in four weeks from the date of the accident. In those cases in which radial displacement is the principal deformity I have obtained good results by the use of a newly designed splint consisting of a piece of wood hollowed out to fit the ulnar border of the hand and forearm and having its metacarpal end made at a slight angle to the remainder of the splint. When in position it fits the forearm and ulnar border of the hand and the latter is neither abducted nor adducted. The radial fragment is drawn or pushed into its place and kept there by a pad which is securely fixed by means of a buckled strap passing round the lower end of the splint. The object aimed at is to keep the lower end of the radius close to the ulna by the pressure of the pad and strap. The splint is a little broader than the ulnar margin of the limb, so as to leave room for the circulation of the blood and lymph. Dorsal and palmar splints are useless for the correction of radial deformity.

The 11 disjunctions of the lower epiphysis of the radius all happened in boys at ages varying from seven to 18 years. At that time of life Colles's fracture is much rarer than disjunction of the epiphysis, but among the skiagrams there is one showing Colles's fracture in a boy, aged 11 years. The cause is indirect violence, such as falling from a height upon the outstretched hand or falling in the street on the palm or ulnar border of the hand. Fracture of the tip of the styloid process was seen in one of five skiagrams that were taken. In one case the epiphyses of both the radius and the ulna were displaced slightly inwards as well as backwards. There is reason to believe that the ulnar epiphysis frequently suffers as well as the radial one, for a few days later there is often a swelling at the spot, due probably to a loosening of the ulnar head and consequent epiphysitis. Permanent deformity or arrest of growth is quite exceptional in these cases.

Belfast.

A CASE OF ACUTE HÆMORRHAGIC PANCREATITIS; OPERATION; RECOVERY.

BY T. C. LITLER JONES, F.R.C.S. ENG.,
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A MARRIED woman, aged 26 years, was admitted into the Liverpool Royal Infirmary on Oct. 1st, 1904, with signs of intestinal obstruction. Her history was that except for constipation she had always been in the best of health. No history of indigestion, colic, or jaundice could be obtained. Her periods were quite regular, the last one starting six days before admission. She had had two healthy children. The patient stated that for the last year her constipation had been worse and that her bowels had not been opened more frequently than once a week and sometimes but once a fortnight. Early on the morning of Sept. 30th, whilst turning in bed to reach the baby, she was seized with a severe pain in the abdomen, as if "something had twisted." She had had no motion of the bowels for seven days but went to the closet and passed a small hard motion. The pain being now more severe she sent for a medical man who administered a small dose of morphine and an enema. During the day she had 12 enemata but passed nothing except a little flatus. She was sick ten times. On the day of admission she was sick twice but it was noticed that her abdomen was more distended. She reached hospital about midnight on Oct. 1st, nearly 46 hours after the "accident." Her condition on admission was as follows. She was a well-nourished, well-built woman, with an anxious expression, a dry mouth, and a very foul, furred tongue, which latter condition was out of all proportion to the severity of the case. Her abdomen was distended, there were signs of free fluid in the flanks, and there was a painful area in the epigastrium with localised swelling. Per rectum and per vaginam nothing abnormal was discovered. The pulse, which was 128, was feeble and fluttering. Her temperature was 96·2° F. It was obvious that some accident had occurred in her abdomen and the diagnosis was that of some gastric lesion, possibly perforated gastric ulcer.

The abdomen was opened in the middle line above the umbilicus and on dividing the peritoneum there at once issued a large quantity of bright blood mixed with serum. Probably three pints of free fluid were in the peritoneal cavity. The intestines were only moderately distended. Although her history negatived a ruptured extra-uterine pregnancy I examined the pelvic contents first and finding nothing abnormal proceeded to investigate the condition of

the other abdominal viscera. Seeing at the entrance to the lesser sac of the peritoneum fat necrosis I made an opening through the gastro-colic omentum and found the affected organ. The pancreas, which was about three times its normal size, was discoloured, œdematous, and in places hæmorrhagic. There was no bleeding at the time of the operation from the pancreas. I now mopped out from the abdomen the blood and serum and removed from the omentum a small piece of fat for microscopical diagnosis. Having packed the area around the pancreas with gauze I incised that organ longitudinally. Introducing my finger I searched for an obstruction such as a stone or an abscess but found nothing that would account for the condition. My finger gave me the impression of entering a dilated space, which space I packed with sterilised gauze. This packing arrested the hæmorrhage which was never as profuse as I had expected and which at all times could be controlled by moderate pressure. The end of the gauze packing was brought out of the abdomen, the wound was closed in its lower two-thirds, and the patient was returned to bed, having borne the operation well. The packing was cautiously removed in 36 hours' time, when a discharge of clear fluid began and continued. This was pancreatic juice and it soon caused trouble at the upper part of the incision, the lower two-thirds of the wound healing by first intention. Apart from an abscess which formed in the abdominal wall, owing, perhaps, to the tube being taken out a little too soon, the patient made an uninterrupted recovery, leaving the hospital quite well, with the wound firmly healed, on Dec. 10th. For the first three weeks after the operation fat-containing food was withheld as much as possible. Her urine was most carefully examined on two separate occasions and nothing in the nature of the crystals described by Cammidge could be obtained. A motion which was passed naturally on the day following the operation was apparently normal and no history of any previous alteration in the appearance of her evacuations could be elicited.

With regard to the pathology of the condition nothing very definite is known. Mayo Robson and Barling emphasise the association of this condition with gall-stones; knowing this I looked carefully for any sign of such at the operation. Halsted, arguing from a necropsy after an unsuccessful operation for acute hæmorrhagic pancreatitis, where the duodenal orifice of the duct was obstructed by a minute calculus, suggested that the bile entered the pancreatic duct by retrojection from the common duct. Opie performed experiments to test this opinion and his conclusions are that the necrosis of the parenchymatous cells and the hæmorrhage represent the primary action of the bile, and that inflammatory action rapidly follows. Mayo Robson asserts that the immediate cause of the various forms of pancreatitis is bacterial infection. Heaton showed specimens of a very similar case recently.[1] In his case the ducts were patent and the microscopical sections showed acute inflammatory changes in the gland and areas of blood extravasation. Deaver, in the American *Medical News* of March 5th, 1904, strongly advises early operation as giving the best results. He recommends free drainage to check progressive necrosis of the pancreatic cells due to the action of the ferment and says that a tense œdematous condition of the organ, without marked involvement of the peripancreatic tissues, calls for an incision in its long axis. The points of interest in this case, apart from its rarity, are the age of the patient, the extremely foul, furred tongue, the absence of any known cause, the difficulty in diagnosis, and the uncertainty of treatment.

Liverpool.

THE HISTO-PATHOLOGY OF SEBORRHŒA, SEBORRHŒIC DERMATITIS, AND PSORIASIS.

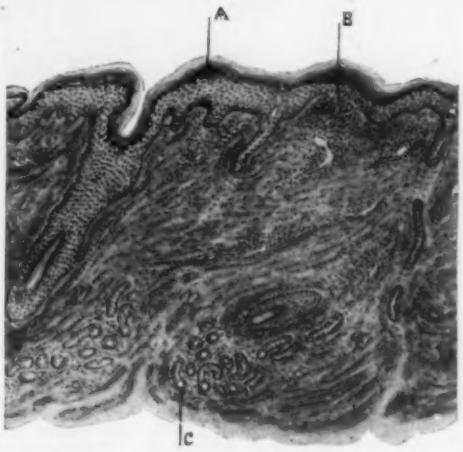
BY R. W. BRIMACOMBE, M.D. BRUX.,
ASSISTANT PATHOLOGIST, ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN.

THAT there is a connecting link between seborrhœa, seborrhœic dermatitis, and psoriasis has been recognised by dermatologists, although as far as I am aware only from a clinical point of view. It is my intention in this paper to demonstrate their connexion as seen under the microscope.

[1] Brit. Med. Jour., Dec. 17th, 1904.

I shall, however, adhere to Sabouraud's definition of the word seborrhœa, "flux of sebum," and consider that seborrhœa should be restricted only to those cases in which there is a sebaceous hypersecretion. In all such cases there is hypertrophy of the sebaceous glands. That seborrhœa persists throughout life without any other change is evident, that a dermatitis is liable to develop is certain, and consequently we have seborrhœic dermatitis. In these cases, as I shall show, the secretion is mainly sudoriparous, as the sebaceous glands have become atrophied. Taking a section of a papule at this stage the most striking feature in a microscopical specimen is the partial and in most cases total disappearance of the sebaceous glands. There are, however, other important changes. The horny layer shows slight increase of horny cells—that is to say, increase in depth of layer—but here and there are small areas showing a greater development of horny cells (piling up) in which are included a few deeply stained leucocytes (polynucleated cells) (A). This is due to the increased capillary circulation in the cutis pushing up or flattening out the epithelial layers. The epithelial layers themselves are slightly increased, due to a swelling of the epithelial cells and dilatation of the lymph spaces between them. Where the narrowing of the epidermis has taken place the leucocytes pass from the capillary circulation through the dilated lymph spaces into the horny layer and it is here the more highly developed horny cells form a kind of roof to these leucocytes (B). At this same point the stratum mucosum cells are flattened, the nuclei of which are slightly swollen, and the protoplasm of the cell does not take the stain so deeply as that of the normal cell. The capillary circulation throughout is increased but it is especially at this shrinking of the epidermis that the greatest development takes place. The endothelial cells are swollen and an inflammatory exudation takes place in which are seen the mononucleated and polynucleated cells. This thinning of the epidermis and increase of the horny cells naturally suggest to one the starting point of psoriasis. The changes which have taken place in the cutis, apart from the atrophy of the sebaceous glands previously mentioned, are the hypertrophy of the sweat glands with wideness of lumen and swelling of epithelium (C). (Fig. 1.) I should,

FIG. 1.



Section of seborrhœic dermatitis papule.

however, mention that in some very few cases there is only marked atrophy of the sebaceous glands and in these the cubical cells forming the wall of the gland and the sebaceous cells are very wasted. Where a papule appears over a hair follicle—more often it does not—the follicle becomes dilated and filled out with horny material only. Here, then, it seems to me we have a definite cause for seborrhœic dermatitis and can dispense with the micro-organism theory put forward by continental dermatologists and seconded by the Americans. That micro-organisms are present is evident but they are due to secondary inoculation and are readily

demonstrated in healthy subjects. Surely if the coccus is the cause of seborrhœic dermatitis we ought to be able to find it in the deeper layers of the skin and not only in the horny layer. The sebaceous glands having failed the sweat glands take on an extra amount of work and become hypertrophied in the attempt to keep the skin normally lubricated. This they fail to do and the amount of secretion being altered accounts for the dermatitis. That the secretion at this stage is a sudoriparous one bears out Unna's theory that he has found fat in the coil glands and believes the coil glands to be the source of most of the fatty secretion characteristic of eczema seborrhœicum. Fat globules, however, are readily demonstrated in the normal coil glands.

Clinically, cases of seborrhœic dermatitis and psoriasis mixed are numerous, also cases of seborrhœic dermatitis passing on to psoriasis, but microscopically the connexion between the two so-called diseases becomes evident. In psoriasis the horny layer is well developed, the cells showing well-marked nuclei on account of the cell being softer and not having acquired that characteristic horny condition as seen normally. That is to say, the process of cornification is incomplete and is due to the rapid formation of scales. Between the horny cells are seen some atrophied wandering cells—polynucleated leucocytes (A). The stratum granulosum cells become flattened without well-marked granulation (B) and the stratum mucosum cells are swollen, with dilatation of the lymph spaces between them. The inter-papillary cone (C) shows high development and is pushed down into the cutis. The papillæ (D) are widened, the connective tissue œdematous and staining badly. (Fig. 2.)

FIG. 2.

Section of patch of psoriasis.

The capillaries in these spaces are dilated and increased with surrounding leucocytosis. Owing to the development of the capillaries and consequent pressure the whole epidermis becomes thinned and the epithelial cells flattened out, only one or two layers of the stratum mucosum remaining instead of the eight or ten normally. This condition, together with the dilated lymph spaces, accounts for the leucocytes wandering amongst the horny cells and the well-known clinical sign of a readily bleeding surface after removal of the scale with the finger-nail.

As in seborrhœic dermatitis, so in psoriasis the cutis shows the most important changes. There is a great increase of connective tissue with swollen bundles and proliferation of connective tissue cells. The lymphatics and blood-vessels are dilated with infiltration of leucocytes around their walls. The sebaceous glands as a rule are absent but occasionally they are present in a very atrophic state. The most noticeable feature, however, is the atrophic condition of the sweat glands and duct. I do not mean to infer that they are completely atrophied or useless. All stages are seen both in the duct and the glands, from the swollen epithelium in one part to the atrophic condition of the cells in another and their total disappearance elsewhere (E). Where the swollen epithelial cells are present there is wideness of the lumen of both duct and glands and where atrophic cells are present the lumen is narrowed and in some cases closed up by the approximation of the two atrophic cellular layers. The duct of the sweat glands is increased in length, having to accommodate itself to the greater increase of cutis and the lengthened duct is probably due to the pressure on each side of it of the œdematous connective tissue. The atrophy is also to be explained in a great measure by disuse. In old-standing cases of psoriasis the œdema of the connective tissue has disappeared and the depth of the cutis more closely approximates that of the normal. It is also in these cases that the atrophic condition of the sweat glands and duct is most marked. The natural secretions of the skin failing, the accompanying inflammation must be looked upon as a secondary process and not as stated by Unna and Elliott "to be a primary affection and not a disturbance in secretion."

Cavendish-square, W.

A CASE OF ENDOCARDITIS WITH PERICARDITIS FOLLOWING SCARLET FEVER; TREATMENT BY ANTI-STREPTOCOCCIC SERUM; RECOVERY.

BY ALFRED R. SPENCER, M.B. LOND., M.R.C.S. ENG., L.R.C.P. LOND.

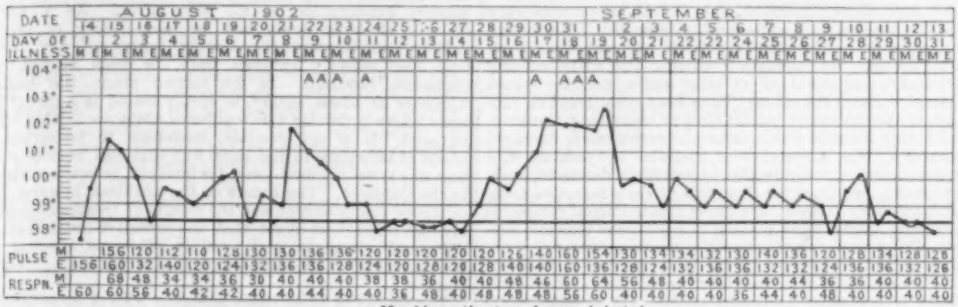
THE following case is of interest for two reasons—first, because antistreptococcic serum, although of proved efficiency in other conditions, is still on its trial in cases of endocarditis of malignant type, and secondly, because endocarditis and pericarditis are not common sequelæ of scarlet fever.

The patient, who was a boy, aged five years, was taken to the South-Western Hospital of the Metropolitan Asylums Board on June 22nd, 1902, suffering from scarlet fever. He was transferred to the Board's Northern Hospital at Winchmore-hill, N., as a convalescent on July 22nd. While at the South-Western Hospital he had otorrhœa of both ears early in July, but on arrival at the Northern Hospital both discharges had ceased. He had never had rheumatism but had always been a weakly child. There was cardiac trouble on the father's side and the mother had had rheumatic fever three times, her last attack being shortly previous to the patient's birth. After his transfer on July 22nd the patient had been up and about up to August 13th. His temperature on the night of August 13th was found to be 101° F. and it continued so till the early morning of the 14th, dropping to 97·6° later in that day. In the evening it was again 101°. The patient was now definitely ill, restless, and complaining of slight pain behind the right ear but chiefly of pain on the right side of the chest; he had also slight cough. His respirations were rapid, being 48 per minute in the evening; at night they were more rapid still—namely, 60 per minute—and he was in great pain and distress. On examination the fauces were found to be reddened; some loose mucous exudate was also seen on them and on the posterior pharyngeal wall. The chest was fairly covered and was of fair shape and size; there was no obvious bulging of the præcordium or of the bases of the lungs. Cardiac pulsation was seen and felt over the cardiac area in the fourth and fifth intercostal spaces of the left side outwards as far as the nipple line. The impulse was forcible but showed some irregularity in both force and rhythm. There was no cardiac thrill. No pericardial or pleural friction was felt. There was some impairment of the movement of the left base in the axillary line. The lungs showed signs of pleurisy and slight patchy consolidation at the left base in the axillary line and in both bases posteriorly. The area of maximum intensity of the cardiac impulse was just internal to the nipple line in the fifth space. The right and upper

limits of dulness were normal; the left limit was just internal to the nipple line. Auscultation of the heart revealed at the apex a well-marked somewhat rough systolic murmur which was heard over the area of maximum intensity of impulse and was localised to this area. Also, localised to this area a pericardial rub was heard at the end of the systolic murmur and throughout the diastole; this rub was confined to the region of the apex. Over the pulmonary and tricuspid areas the heart sounds were embryonic in character. At the aortic cartilage the first sound was weak.

On August 15th his temperature was 101° and his pulse quickened to 156 per minute, from 130 on the day before. On the 16th there was a morning fall of temperature. The cardiac impulse was seen and felt half an inch external to the nipple line. No pericardial sounds were heard. On the 18th the cardiac impulse was three-quarters of an inch external to the nipple line but the outer limit of the cardiac dulness was one inch external to it, and the upper limit of the dulness reached the lower border of the second rib. On the 20th pulsation could be seen in the third, fourth, and fifth intercostal spaces and percussion revealed dulness in the first and second spaces close to the sternum. The skin showed a raised confluent erythema in irregular patches, gyrate, scattered on the trunk and more widely scattered on the limbs. There was none on the face and there was no irritation. Later in the day there were diarrhœa and also vomiting of the contents of the stomach. On the 21st the diarrhœa and vomiting continued; at times there was some irregular sweating; the facial expression was anxious and frightened as though the patient were fearful of some impending calamity and there was much respiratory and cardiac distress. The eruption continued to spread; it was still gyrate; it was paler centrally than at the periphery, where there was a well-marked border, dusky purple-red in colour. On the 22nd the patient was prostrate in bed, apparently unconscious of his surroundings and possessing very little control of the sphincters. His tongue was dry; the teeth and lips were covered with sordes; the pulse was flickering; his temperature was 101° at 10 A.M. There was profuse sweating at irregular intervals. The eruption had spread so that the trunk was almost covered. At 1.20 P.M. ten cubic centimetres of antistreptococcic serum were injected hypodermically into the loose tissue of the flanks. His temperature at 6 P.M. rose to 102·2° and at 10 P.M. dropped to 100·6°. Ten more cubic centimetres of serum were given. On the 23rd the patient was much better, the rash was fainter, and the sweating was less copious. Ten cubic centimetres of serum were given at 12 noon. His temperature at 10 P.M. was 99°. On the 24th the rash was almost gone. There was obvious bulging of the præcordium and pulsation was diffuse in the third, fourth, and fifth intercostal spaces. The cardiac impulse was three-quarters of an inch external to the nipple line but the outer limit of the cardiac dulness extended outwards to the anterior axillary line. The results of auscultation were as follows. Succeeding the systolic murmur at the apex there was a diastolic murmur replacing the second sound. At the base, over both pulmonary and aortic cartilages, there were soft systolic murmurs followed by a sharp second sound. There was also a shuffling pericardial friction sound, altering in the time of its occurrence with reference to the cardiac cycle. There was no enlargement of the liver or spleen.

On the 25th and 26th the temperature did not reach above 99°. On the 28th it rose to 100°. There was on the abdominal wall an irregular papular rash, light pink in colour, fading on pressure, quite symmetrical on the two sides, and bounded laterally by the nipple lines; towards Poupart's ligament it became a raised erythema in large scattered patches, darker in colour than above described, and its colour was more persistent on pressure. This rash did not extend below Poupart's ligament and on the next day it had almost disappeared. On the 30th bulging of the præcordium was much more marked and dulness extended over the inner ends of the first and second intercostal spaces on the left side for one and a half inches. The liver dulness extended a finger's breadth below the right costal margin. Injections of serum were recommenced as shown on the accompanying chart.



At night the patient was very restless and was observed to lie chiefly on his left side but he did not complain of pain. The respirations varied much in amplitude and frequency, at times assuming a Cheyne-Stokes character; the diaphragm moved normally. On the 31st there was some reappearance of the rash; the inguinal glands were enlarged and tender. The pulse-rate was 156 and the temperature was 102·4°.

On Sept. 1st pulsation was seen over the whole of the præcordium and in the left mid-axillary line in the fourth and fifth intercostal spaces. Dulness extended outwards to the left mid-axillary line below and reached in the third space to the nipple line. A to-and-fro pericardial rub was heard at the inner ends of the second, third and fourth spaces and over the sternum adjoining. At the base of the left lung behind and in the axilla there were signs of compression of the lung. The axillary glands were slightly swollen, those on the left side being tender as well. On the 3rd the dulness on the right side of the heart was extending in the lower spaces. On the 6th signs of lung compression were well marked at the left angle of the scapula. Over the aortic cartilage there was a systolic murmur conducted up into the carotid arteries and heard over the subclavian. On the 7th two large irregular patches of erythema appeared on the skin of the abdominal wall with a few faint spots on the thighs. There was pain over the left hypochondrium and friction fremitus was very well felt over the inner ends of the intercostal spaces, especially close to the sternum. The patient was very wasted and very pale. On the 8th the bulging over the præcordial area was a marked feature at this stage, as also the pulsation visible over the whole area, somewhat undulating in character. On the 11th auscultation at the apex revealed a whistling systolic murmur, preceded by a rough, loud, harsh presystolic murmur. Over the aortic cartilage there was a well-marked to-and-fro murmur; capillary pulsation was not obtained.

By Sept. 22nd the patient was assimilating food well and was not wasting so much. By the 29th the fluid in the pericardium was practically absorbed; there were signs of pericardial adhesion and of much dilatation of both left cardiac chambers. The aortic murmurs had cleared up and the pulmonary sounds were then embryonic in character.

On Oct. 20th the patient's appetite was good and he was gaining strength and flesh rapidly. The cardiac impulse extended outwards to the anterior axillary line in the sixth left intercostal space and did not change as the patient changed his posture. In the fifth space, internal to the position of the impulse, there was some systolic recession. There was some impairment of the percussion note at the

inner ends of the first and second left spaces for an inch or more. The cardiac dulness on the right side did not extend across the middle line. On auscultation both sounds at the apex were found to be replaced by murmurs. The systolic murmur was rough and loud; it was heard best at the point of impulse but was conducted out to the axilla, and was heard also over the whole of the cardiac area and over the whole of the back of the chest. The diastolic murmur was very soft, blowing, and quite localised to the apex and neighbourhood.

Summarising the general features of the case it may be remarked that the patient did not suffer from rheumatism or joint trouble. A systolic murmur localised to the apex may occur in patients convalescent from scarlet fever; this murmur disappears later and is probably hæmic in origin or arises in connexion with the slight cardiac dilatation so often met with in these convalescent cases. It is evident that in the case above described the mitral valve was very definitely affected and permanently impaired. The aortic murmurs, which subsequently cleared up, may have been due to pressure of exudation outside the aorta causing functional derangement of valvular action, and the return to normal valvular action may have been consequent on subsidence of the exudation; at the time of recurrence, however, it was feared that the aortic valve was permanently damaged structurally. The occurrence of irregular temperature with a cardiac murmur, accompanied by vomiting, diarrhœa, rash, and sweating, rendered the diagnosis of early infective endocarditis tolerably certain. The grave constitutional symptoms observed on August 22nd pointed to a profound toxæmic condition, with probable involvement of nerve centres.

With regard to the use of serum treatment in cases of infective endocarditis I find that up to the date of this patient's illness eight instances of the use of antistreptococcic serum in such cases had been published in THE LANCET and opinion was divided as to its efficacy; of the eight then reported cases four had recovered and four had died.

From a study of these published observations it is clear (1) that the earlier the treatment is begun the better is the hope of recovery; (2) that it is undesirable to wait for a positive confirmation of the diagnosis, such as embolism or infarct, before beginning treatment; and (3) that the size of dose should be regulated, not by the age of the patient but by the gravity of his or her condition.

The accompanying temperature chart is a *résumé* of a four-hourly chart; it shows the temperatures at 10 A.M. and 10 P.M. but does not show the daily remissions as clearly as they occur on the four-hourly chart. The improvement with serum in each case is apparent.

After I had written the above Dr. Cyril Ogle published in THE LANCET of March 14th, 1903, p. 720, a *résumé* of 19 recorded cases of malignant endocarditis treated with the serum in which an attempt was made to identify the organisms present. Of these some were mixed infections; in seven of the cases streptococci had been found in the blood; of these seven three cases of recovery were reported with only one recovery in the case of the others. Dr. Ogle's conclusions were (1) that though, taking all cases of septicæmia treated with the serum, there was a certain chance of recovery in most, yet in malignant endocarditis the chances were less favourable on account of the colony of cocci involved in the vegetations being in constant contact with the blood stream; (2) that the occurrence of staphylococci, or a mixed infection, was frequent; and (3) that if examination of the blood prove negative then it would be prudent to inject sera "anti" to both varieties of organism.

With regard to the nature of the micro-organism present in acute cardiac conditions in infectious disease it may be interesting to state that in the Western Hospital of the Metropolitan Asylums Board at Fulham I had under my care a case of acute pericarditis coming on early in the acute stage of scarlet fever; the illness proved rapidly fatal, and cultivation of the blood taken before death gave a copious pure culture of staphylococci.

I am indebted to Mr. F. N. Hume and Mr. R. M. Bruce, medical superintendents of the Northern and Western Hospitals respectively, for their permission to publish the above.

FIFTEENTH INTERNATIONAL CONGRESS OF MEDICINE AT LISBON.—Dr. R. Saundby has accepted the post of reporter in the Section of Medicine on the subject of the Treatment of Cirrhosis of the Liver.

TRAUMATIC LUMBAGO.

BY FRANK ROMER, M.R.C.S. ENG., L.R.C.P. LOND.

By traumatic lumbago I mean a condition in which pain and stiffness in the lumbar region caused by injury persist long after the immediate and acute effect has passed away. Many such cases have come to my notice and they have shown good results from treatment based on the assumption that the condition is due to some adhesions in the muscular or tendinous structures of the lumbar region.

It is obvious that absolute proof of the exact lesion in cases of this kind is not to be found. In the first place, if the subjects of this complaint come under treatment they are fortunately very unlikely to be the objects of a post-mortem examination at all soon after. As a matter of fact, I have never had an opportunity of investigating post mortem the lumbar region of any person who had recently suffered from, or been treated for, traumatic lumbago. In the second place, the damage, whatever its exact nature, is deeply seated in a part of the body where muscular and tendinous fibres are thickly superimposed. It is not possible, therefore, to be certain of bands or adhesions in the same way that can be done in the case of a knee- or elbow-joint, for instance, or between viscera in the abdomen. The nature of the accident, however, that produces the condition and the results of treatment leave in my own mind little doubt that the causative lesion is of the nature of adhesions, and possibly adhesions affecting the bony structure of the sacro-iliac joint, as well as neighbouring tendons.

The history of these cases generally tells of some definite, though frequently slight, sprain or rick of the back, necessitating, perhaps, but a few days' rest for apparent recovery. Instead, however, of perfect recovery the pain, though rarely severe, does not quite disappear and as time goes on becomes more persistent. Lumbar stiffness increases and a condition arises similar to that of chronic lumbago. In the majority of these cases pain, though present in the whole lumbar region, is especially referred to one defined spot in particular. Treatment is then usually instituted on the supposition that ordinary lumbago is the condition to be dealt with. Such treatment is of little or no use in the cases to which I am referring.

On examination the lumbar muscles generally are found to be wasted, whilst on the affected side they are usually also rigid and contracted. It may be assumed that it is here that some matting of the muscles or adhesions amongst the deeper tendons exist. In making this examination my first care is to exclude the possibility of the case being one of early spinal caries. This being determined treatment aims at stretching the contracted muscles and rupturing the adhesions which are deemed to be present. An anæsthetic is given both for the prevention of pain and to insure complete muscular relaxation and absolute freedom in manipulation. The patient is placed on his back, the leg on the sound side is flexed at the knee, and the thigh is flexed on the body till the knee touches the chest wall. It is then brought back to the extended position. The leg on the affected side is now put through the same movements and comparison can be made as to the difference in resistance. Almost invariably it will be found that the leg of the affected side is not brought up with the same ease as was the other. Both legs are now brought up together and both knees should be kept pressed against the chest for about a minute. The legs are now brought down again flat on the bed and the patient is raised to a sitting posture. The operator places one hand firmly over the affected lumbar region, whilst with the other he thrusts the patient back towards the bed. The hand in the small of the back causes the part against which it is placed to be extended. By this procedure the lumbar portion of the spinal column is put through flexion and extension as the patient is pressed forwards and backwards. As a rule little pain is experienced after the manipulation and there is no need to enforce rest once the effects of the anæsthetic have passed off.

The after-treatment is directed towards the maintenance of movement, for which purpose it is advisable to have the lumbar and gluteal muscles skilfully shampooed within six hours of the operation. In the course of a few days exercises graduated by means of pulleys and weights should

be commenced in addition to the rubbing. These serve both to restore the muscle waste and to keep the part supple. Later swimming is the finest of all exercises for the same purpose. With the increase of strength there are freer movement and decrease of pain. I append brief notes of the following cases as examples of traumatic lumbago.

I may say that Case 1 illustrates remarkably well the kind of accident which is liable to cause the damage that results in traumatic lumbago. The patient, a strongly built young man, was returning from the hunting field. He was leaning sideways to stop a swinging gate when his horse suddenly swerved. The twist suddenly given to his back in the effort to retain his seat caused immediate sickening pain in the lumbar region. The dull pain that subsequently persisted was well localised to a small portion of the left lumbar region. All treatment failed till the proceedings above described were carried out. The result was complete recovery.

CASE 1.—The patient, a male, aged 28 years, sprained and twisted the left side of the back eight months previously. He rested a fortnight absolutely but had never recovered lifting power. There was dull pain in the lumbar region. For the past two months this had been worse and he had laid up again. This gave no improvement. He had tried treatment for rheumatism. He was operated on as described above and also shampooed and exercised afterwards. In two months' time he was able to play cricket and to ride free from pain. (He has remained well for six years.)

CASE 2.—The patient, a male, six months previously sprained the right sacro-iliac region lifting his wife who was ill. After this he spared it as much as possible. It had been painful off and on ever since, more continuously for the past few months. No treatment but rest had been tried. He was operated on as described above and shampooed and exercised. He did well. I saw this patient recently. He has been sound since the treatment and has hunted regularly.

CASE 3.—The patient, a male, sprained his back 18 months previously while gold digging in the Transvaal. No treatment was tried at the time but he rested off and on till four months previously. He then saw a medical man who treated him for rheumatism. He wore menthol plasters and he rested. Pain on movement or lifting still persisted, especially in the left lumbar region. He was now unable to ride or to row. When I saw this patient the lumbar muscles were very wasted and contracted, especially on the left side. I operated on him in the manner described. Afterwards he was shampooed and exercised. Marked improvement took place within ten days. When last seen he was able to ride and to walk about freely with very little pain.

CASE 4.—The patient, a male, sprained his back wrestling three years previously. He rested. Again at football three months previously he repeated the injury. Absolute rest was instituted. Pain on attempting to lift anything from the ground, especially on the left side, persisted in spite of prolonged rest. The left lumbar muscles were rigid and contracted. He was treated as the preceding case. He did very well and when last seen was entirely free from pain with perfect movement.

CASE 5.—The patient, a male, four years previously "ricked the back." Eight months previously he ricked it again. He kept quiet for a few days. Pain had been constant of late. Riding was painful and lifting was painful, with loss of power, especially on the left side. No treatment was tried but rest. The lumbar muscles on the left side were rigid. Movement was impaired. Operation was carried out as described above with shampooing and exercising. He was practically sound in three weeks. He is now able to bend and to lift with ease.

CASE 6.—The patient, a male, in May, 1903, on moving quickly experienced sudden and acute pain in the lumbar region, entirely incapacitating him. He was treated for lumbago. In the following August he was worse. Rest and rheumatic treatment were tried. Massage improved the condition. On attempting exercises three months previously he became much worse. He tried Droitwich for six weeks with heat baths. There was no improvement. The patient had been an athlete and was powerfully built. In November, 1904, he was unable to stand straight and sitting any length of time caused lumbar pain. There was considerable lateral lumbar curvature and he was doubled up, as in extreme old age. The lumbar muscles were so contracted that movement was nearly impossible. I operated as in the previous cases. Shampooing and exercises followed. He began to show immediate improvement. He was able to lace his boots within a week and within a month to touch his toes without bending the knees. He then went to the country to carry on treatment for himself but returned in two months, having strained himself in the right lumbar region. I stopped the exercises and ordered him to be shampooed only. Gradual improvement followed. Pain is now (January, 1905) practically absent, the curvature has disappeared, and movement is nearly perfect. This case was particularly interesting from the extraordinary amount of deformity present.

Cases 1 and 2 I saw with my partner, Dr. Wharton P. Hood, who first advocated this treatment and it is with his permission that I publish them.

Seymour-street, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A NEW METHOD OF ACCURATELY EXAMINING THE HYMEN IN MEDICO-LEGAL CASES.

BY J. LIVINGSTONE LOUDON, M.D. GLASG., D.P.H.

IN all cases of alleged rape it is of the utmost importance that the condition of the hymen should be ascertained and if it has sustained any injury the full extent, nature, and position of it accurately estimated. Of course, it is only in cases where the victim has up to the time of assault been a virgin that the hymen will most likely show traces of injury and the younger the woman the more difficulty there is in making an examination which is at the same time painless and yet thorough.

The following method of thoroughly exposing the hymen I have frequently found most effectual; it is, moreover, simple, easily managed, and, if done carefully, painless. The patient being in the lithotomy position and swabs from the vagina (for examination for semen) having been taken the parts are freely treated with a 20 per cent. solution of cocaine, possible toxic effects where there are large raw surfaces being kept in mind. An ordinary soft red rubber catheter is then taken and over its point for about one inch or one and a half inches there is placed an ordinary indiarubber condom which is tightly bound into the stem of the catheter by a few turns of thread. There is thus improvised an instrument closely resembling one which used to be employed for arresting hæmorrhage in cases of epistaxis, the armed catheter being placed in the nose and the point inflated and so caused either to press on the bleeding point or plug the nostrils. This arrangement is gently passed into the vagina; the point is then expanded either by inflation or by injecting a small quantity of warm water; this done the catheter is clamped. There now is inside the hymen what may be termed a miniature Champetier de Ribes bag and by making *very gentle* traction on the catheter the hymen is put slightly on the stretch and bulged from within. In this way the whole hymeneal margin is fully exposed to view, so that any interruption in its integrity is at once detected, however slight it may be. In very young girls this method will be found particularly useful, as the hymen is very inaccessible then.

Hamilton, Lanarkshire.

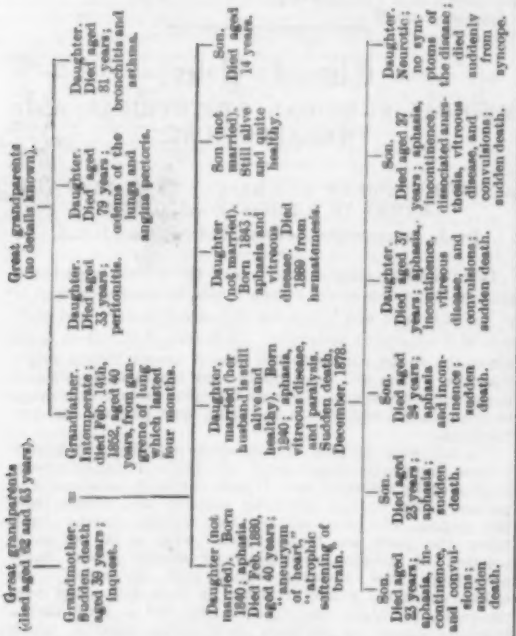
A NOTE ON A CASE OF HEREDITARY APHASIA.

BY W. GREAM STONE, M.A., M.D. OXON., F.R.C.S. ENG.

THE following case, for the details of which I am indebted to Mr. R. H. Jocelyn Swan, is reported to complete a series of cases published in the autumn number of *Brain*, 1902. The patient was the last survivor of a family of six, five of whom had suffered and died from this disease, which also affected their mother and two of her sisters. The main clinical features of the disease, which does not appear to show itself until the patient is attaining to adult life, are the following: (1) attacks of temporary aphasia with loss of power on the right side of the body; (2) incontinence of urine, probably due to analgesia of the bladder wall; (3) gradually increasing opacities in the vitreous humour of the

eyes; (4) loss or diminution of the senses by which pain and temperature are appreciated; (5) epileptiform convulsions; and (6) sudden death preceded by complete unconsciousness. The pathology of the disease in the only case in which there was [an opportunity of examining the organs after death proved to be a spinal leptomeningitis which extended from below upwards until the cerebral meninges were affected in a like manner; the posterior columns of the cord and the posterior nerve roots showed well-marked degeneration.

The following family tree will show the number of children in each generation and the degree in which they were affected by the disease:—


Great grandparents (died aged 82 and 63 years).
Great grandparents (no details known).
Grandfather. Intemperate; died Feb. 14th, 1852, aged 40 years, from gangrene of lung which lasted four months.
Daughter. Died aged 33 years; peritonitis.
Daughter. Died aged 79 years; œdema of the lungs and angina pectoris.
Daughter. Died aged 81 years; bronchitis and asthma.
Grandmother. Sudden death aged 39 years; inquest.
Daughter (not married). Born 1840; aphasia. Died Feb. 1880, aged 40 years; "aneurysm of heart," "atrophic softening of brain."
Daughter, married (her husband is still alive and healthy). Born 1840; aphasia, vitreous disease, and paralysis. Sudden death, December, 1878.
Daughter (not married). Born 1843; aphasia and vitreous disease. Died 1899 from hæmatemesis.
Son (not married). Still alive and quite healthy.
Son. Died aged 14 years.
Son. Died aged 23 years; aphasia, incontinence, and convulsions; sudden death.
Son. Died aged 34 years; aphasia and incontinence; sudden death.
Daughter. Died aged 37 years; aphasia, incontinence, vitreous disease, and convulsions; sudden death.
Son. Died aged 37 years; aphasia, incontinence, dissociated anæsthesia, vitreous disease, and convulsions; sudden death.
Daughter. Neurotic; no symptoms of the disease; died suddenly from syncope.

The case here referred to is the daughter who died at the age of 37 years. She had suffered from vitreous opacities for nearly ten years and, like one of her aunts, had become quite blind before her death. In its general course the disease in her case resembled that of her mother and aunts, rather than that of her brothers, for the eye symptoms were prominent long before the more marked clinical features appeared and she lived to a very much greater age than any of her brothers, dying at the age of 37 years, while they died at 23, 23, 24, and 27 years of age respectively. This suggests a tendency on the part of the disease to take a different course in the two sexes, being more chronic in women, with at first much predominance of the vitreous disease, and acuter in men with early spinal symptoms. Ultimately this patient appears to have exhibited the complete syndrome of symptoms with the exception, perhaps, of the dissociated anæsthesia for she had frequent attacks of aphasia with loss of power in the right arm, convulsions of great violence and long duration, incontinence of urine (and finally also of fæces), and coma for some hours before death. It is unfortunate that no post-mortem examination could be obtained in her case to corroborate the pathological changes found and reported in the case of her brother.

Denmark-hill, S.E.

UNIVERSITY OF OXFORD: BOARD OF FACULTY OF MEDICINE.—The following have been elected members of the Board of Faculty of Medicine and will hold office until February, 1907: Sir William Selby Church, Bart., D.M., Christ Church, Honorary Fellow of University College; Walter Ramsden, D.M., Fellow of Pembroke College; Ernest William Ainley Walker, D.M., Fellow of University College; Walter William Fisher, M.A., Corpus Christi College; Samuel Hatch West, D.M., Christ Church; and William Bruce Clarke, B.M., Pembroke College.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

BOLINGBROKE HOSPITAL, WANDSWORTH COMMON, S.W.

SOME CASES OF ABDOMINAL INJURIES IN CHILDREN.

(Under the care of Mr. HAROLD BURROWS.)

CASE 1. *Ruptured intestine.*—A boy, aged nine years, was admitted to Bolingbroke Hospital on August 22nd, 1903, 24 hours previously, while playing in the street, he had been knocked down by a brougham, both wheels of which, it was said, had passed over his body. The occupant of the carriage at once got out and inquired how much the boy was hurt, but he declared that he was not hurt at all and subsequently he walked home, a distance of a quarter of a mile. A medical practitioner who was requested to visit and to examine the patient was unable to find any evidence of a serious injury and assured the parents that there was no harm done beyond a few bruises. However, shortly afterwards the patient began to have pain in the abdomen which soon became severe; vomiting then commenced and was repeated at intervals throughout the night and the next day, and the abdominal pain became intense. On his admission to the hospital the patient was in great pain and was frequently retching and vomiting. He said that the shaft of the carriage struck his forehead—where there was a bruise—and that both wheels had gone over his stomach. His pulse was of small volume with a frequency of 128. The abdomen was moderately distended and rigidity and tenderness were marked. There was a bruise extending from the right hypochondrium to the left inguinal region. Light percussion over the region of the liver produced a tympanitic note. Perforated bowel was diagnosed and immediate operation was performed. A median incision was made above the umbilicus and gas escaped from the peritoneal cavity. There was diffuse peritonitis. About 12 inches from the duodeno-jejunal flexure the jejunum was found to be divided completely except for a strip of mucous membrane which remained untorn near the mesenteric attachment. Much bile-stained material had escaped into the peritoneal cavity from the bowel. The gut was united, the peritoneum was cleansed by sponging, and the abdominal wound was sutured. The patient did not rally and died 12 hours after the operation.

CASE 2. *Lacerated mesentery.*—A boy, aged five years, was admitted to Bolingbroke Hospital on June 9th, 1904, having been run over a few minutes before by a hearse which was carrying to the cemetery the body of a man who had died in the hospital. Mr. E. M. W. Hearn, the resident medical officer, at once diagnosed internal hæmorrhage. On the arrival of Mr. Burrows the patient was pale and collapsed with a pulse of 160. There was dulness in both flanks. A diagnosis of rupture of the liver or spleen was made and operation was undertaken at once. A median incision above the umbilicus revealed blood in the peritoneal cavity, but the blood was mostly below the transverse colon, and an examination of the liver and spleen proved them to be undamaged. The incision was continued downwards and the mesentery was found to be lacerated in no fewer than eight places, several of the rents passing completely through the mesentery, while the largest one extended from the intestine obliquely upwards into the mesenteric root. A large vessel was bleeding at the upper end of this rent. This vessel was ligatured and the three largest rents were sutured with fine silk. The feeble condition of the child made it undesirable to prolong the operation by sewing up the smaller tears in the mesentery. The small intestine was nearly empty and was uninjured. The abdominal wound was then sutured. Although it was feared that the bowel might suffer from injury to its blood-supply no complication of this nature

occurred. Recovery was uninterrupted and the patient was discharged on July 1st.

CASE 3. *Ruptured spleen.*—A girl, aged four years, was taken to the Bolingbroke Hospital on July 26th, 1904, with the following history. She was walking hand-in-hand with another child at a school treat when the horse in the provision cart took fright and bolted, knocking both the children down. A medical man was at once summoned and was requested to examine the patient's companion who had a bruised head but he was told that he need not trouble to examine the other as she was not hurt—indeed, she was sitting in a chair eating a piece of cake and looking quite well. Later in the day she complained of pain in the abdomen and became faint and was taken to the hospital. On her arrival there it was noticed that she had an anxious expression as though there were some abdominal injury. She complained of pain in the stomach and when asked to show where the pain was she placed her hand on the epigastrium. The abdomen moved freely on respiration, was soft, and the only physical signs discovered were slight dulness in both flanks, more marked in the left, and absence of free mobility of the left costal arch. The patient was not pale. The pulse was 140, the temperature was 97·6° F., and the respirations were 32. Immediate operation was not advised but the nurse in charge was requested to keep a half-hourly record of the pulse-rate and to make known immediately any increase of its frequency. Throughout the night the pulse varied between 124 and 140 but at 6.30 A.M. the child appeared suddenly to get faint and the pulse was found to be 168, having been 140 half an hour before. On the arrival of Mr. Burrows soon afterwards he found the child collapsed. There were rigidity and tenderness in the left hypochondrium. The pulse was 176 and the respirations were 32. The abdomen was opened in the mid-line above the umbilicus and blood was at once apparent in the recess between the stomach and the transverse colon. The liver was examined and found to be intact. The spleen, however, was felt to be lacerated. The incision was extended to a short distance below the umbilicus. The spleen could now be brought to view and was seen to be torn in halves by a horizontal rent extending beyond the hilum. There seemed to be no bleeding from the lacerated spleen, but the patient was very faint, no pulse being manifest at the wrist, and the pedicle had to be drawn upon in order to bring the spleen into view, either of which circumstances might have accounted for a temporary arrest of hæmorrhage. The laceration was too extensive to permit of security from renewed bleeding together with conservation of the spleen, so this was removed. Three interlocking silk ligatures were passed beneath the spleen and tied and the spleen was cut away with scissors, a portion of its substance in the neighbourhood of the hilum being left in order to prevent the ligatures from slipping off. Blood was sponged out of the abdomen and the wound was closed. For 48 hours after the operation the child was in a condition of collapse with rapid feeble pulse and shallow respiration. She then began to rally and for the next nine or ten days was in a curious condition. She was dull, drowsy, and apathetic, but if thoroughly roused became irritable and frightened. The pulse remained rapid. On the evening of the ninth day after operation the temperature abruptly rose to 103·2° and the pulse increased in frequency from 92 to 168 beats a minute. The wound was healthy and no physical signs could be discovered which might account for the fever. On the following morning, with the view that the symptoms might be due to loss of the spleen, spleen extract and fresh bone marrow were ordered and one minim of liquor arsenicalis was also given three times a day.

The temperature gradually declined, reaching normal on August 10th, and the child's general condition appeared to improve considerably. A week later she was allowed to get up. She was now quite vivacious and appeared well in every way except that the pulse-rate was somewhat rapid. On August 24th the spleen extract was discontinued. On the following day the patient was listless, disinclined to play, and usually if spoken to would begin to cry. Next day there was more marked indisposition and the child was kept in bed and in the evening the spleen extract was resumed. On the following morning the temperature was 102·6° and the pulse was 150. In the evening the temperature was 99·2° and the pulse was 140. Two days later there was an evening rise of temperature to 101·2°.

Ten days after removal of the spleen enlargement of the lymphatic glands of the neck, axilla, and groins was noticed. The child was discharged on Sept. 1st, five and a half weeks after admission. She is now said to be in good health.

Remarks by Mr. BURROWS.—Abdominal injuries are always interesting and for this reason and also because they permit of some useful comment I wish to place the above cases on record. It is remarkable that in two of the cases—the torn intestine and the ruptured spleen—there were no symptoms to cause a suspicion of the grave injuries received until a considerable time had elapsed after the accident, and although similar cases have been reported before there can be no harm in emphasising their possibility by recording two so striking examples. For it is important to be cautious when called upon to express an opinion on a supposed case of abdominal injury. To give comfortable assurances to the relatives before a few hours have elapsed is to run the hazard of a loss of reputation which will very likely be accentuated at a subsequent inquest. While it is true that a grave abdominal lesion may be present without immediately giving rise to unmistakeable signs of its presence, it is equally true that well-marked "peritonism" is not always an indication of severe abdominal injury. About the time when Case 1 was admitted to the Bolingbroke Hospital a little girl was also taken to the children's ward, having been run over in the street a few minutes previously. Her case forms a marked contrast with Cases 1 and 3. On admission she was pale and collapsed. The skin was cold and sweating, no pulse could be felt at the wrist, the respirations were very shallow, and it seemed as though the child were dying. That there had been some violence applied to the abdomen was manifest, for the right rectus muscle was partially ruptured above the umbilicus. Nothing was done beyond the application of hot bottles and other stimulants. A little later the child had rallied somewhat and the pulse, though very rapid, could be distinguished at the wrist. There now appeared great pain and tenderness in the upper part of the abdomen but the liver dulness was unimpaired and there was no dulness in the flanks. The pulse showed a rapid and continuous improvement and the respirations became deeper. On the following day the child appeared quite recovered except for tenderness in the place where the rectus muscle was injured. No further symptoms developed and the patient was discharged a few days after her admission.

Perhaps the different degrees of sensitiveness of the visceral and parietal peritoneum are sufficient to account for the unreliability of pain as a symptom in abdominal injuries. It has been shown that the visceral peritoneum is nearly insensitive and therefore injury to the gut or spleen without injury to the parietal peritoneum does not cause pain until peritonitis due to hæmorrhage or sepsis has ensued. The child mentioned above as a contrast case may have suffered from a tear of the parietal peritoneum without severe visceral injury. The conclusion to be drawn from these and other similar cases is that symptoms of peritonism do not justify an exploratory operation in cases of abdominal injury unless they persist or else are associated with definite physical signs such as loss of liver dulness, dulness in the flanks, or an increasing frequency of the pulse.

Loss of liver dulness.—There appears to be much difference of opinion among surgeons as to the value of this sign. The confusion is probably due to the different methods of percussion employed. Among 50 consecutive abdominal emergency cases which have recently been under my care loss of liver dulness on gentle percussion was observed in six only, and in every one of these six a perforation of gut other than the appendix was found at the operation or the necropsy. The six cases were as follows: two perforated gastric ulcers, one perforated stomach due to swallowing hydrochloric acid, one perforated duodenal ulcer, one traumatic perforation of the rectum (without a history or external evidence of any such injury), and the case of ruptured intestine referred to above. In no case where liver dulness was present was there a perforated gut (other than the appendix). In only three other emergency cases has there been absence of liver dulness, in one due to a stab wound of the left lung and diaphragm without intestinal injury and in the other two to pneumothorax. One of these is worthy of a brief mention. A boy, four years old, was run over by a cart. There was evidence that the wheel had passed over his epigastrium. The practitioner who first examined him discovered that there was no liver dulness and diagnosed

rupture of the intestine. However, the true nature of the case soon became apparent. There were no broken ribs and two days later the patient was quite well, although a few hours after the injury there was considerable dyspnœa and the respirations were between 50 and 60 a minute. Such cases are not very uncommon in children where injury has been received to the lower part of the thorax.

The following propositions with regard to loss of liver dulness appear to be warranted: (1) that if light percussion over the front of the liver yields a tympanitic note there is free gas between the liver and the percussed finger; and (2) that this gas may have escaped from lung or from stomach or intestine. The highest importance may therefore be attached to loss of liver dulness as a symptom in abdominal emergencies but the percussion must be of the lightest character. Heavy percussion will yield a resonant note over the liver in the absence of free gas if there be much intestinal distension. A tympanitic note elicited by gentle percussion is conclusive proof of the presence of free gas in front of the liver.

Blood in the abdominal cavity.—A striking feature of Cases 2 and 3 was the small quantity of blood found in the abdomen. Although there was sufficient to cause dulness to percussion in the flanks there was by no means a quantity proportionate to the constitutional symptoms of hæmorrhage. It seemed probable that though much blood had been effused it had been rapidly absorbed by the peritoneum. The remarks on the necessity for gentle percussion in testing the liver dulness apply with equal force to the examination for fluid in the flanks. Small quantities will be overlooked if the percussion is forcibly performed.

Medical Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

The Influence of Stigmata of Degeneration upon the Prognosis of Epilepsy.—A Group of Associated Malformations, including almost Complete Absence of the Muscles of the Abdominal Wall and Anomalies of the Genito-urinary Apparatus.

A MEETING of this society was held on Feb. 14th, Sir RICHARD DOUGLAS POWELL, Bart., the President, being in the chair.

Dr. W. ALDREN TURNER read a paper on the Influence of Stigmata of Degeneration upon the Prognosis of Epilepsy. The purpose of the communication was to ascertain, by means of a statistical investigation, whether the presence of structural stigmata of degeneration exercised any influence, and if so to what extent, upon the prognosis of epilepsy. Stigmata of degeneration were defined as structural deviations from the normal, arising during the periods of development and brain growth, in those who were the subjects of a hereditary degenerative predisposition. 100 consecutive cases of confirmed epilepsy from amongst the patients resident at the Colony for Epileptics, Chalfont St. Peter, were examined with this object. The stigmata to which attention was especially directed were: (*a*) Facial, including nasal, deformity and asymmetry. This was found to be more common in females than in males. Although present in 42 per cent. of the total number of cases it was only found in 14 per cent. as a single stigma. (*b*) Deformities of the hard palate. These form some of the most frequent and trustworthy of degenerative phenomena. Abnormal palates were found in 42 per cent. of the cases but only in 17 per cent. as a solitary stigma. (*c*) Deformities of the external ears, indicated by abnormal size, shape, and symmetry, were present in 33 per cent. but in only 9 per cent. as a solitary stigma. (*d*) Dental anomalies and displacements. Brief reference was also made to stammering and high errors of refraction as physiological stigmata. The statistical facts bearing upon prognosis were considered under the following headings:—1. Sex. Of 100 epileptics 62 were males and 38 were females. Males exhibited neuropathic stigmata to a much greater extent than females in the proportion of 52 males to 23 females. Of the total number of cases, males and females, 75 per cent. presented stigmata and 25 per cent. were free. 2. Hereditary history. Owing to the difficulty in obtaining precise and trustworthy information on this point it was not possible to deduce any general conclusions but it was observed that direct parental heredity to epilepsy or insanity was usually associated with more pronounced stigmata than collateral heredity. 3. Age at onset of the convulsions. Those cases in which the disease commenced between birth and five years of age showed a larger percentage of stigmata than at other ages. This was in harmony with what had been shown elsewhere that epilepsy commencing during the first quinquennium was characterised by the highest percentage of cases showing profound mental impairment and was most favourable for the development of the confirmed malady. 4. It was apparent from a study of the duration of the convulsions that the absence of stigmata did not necessarily imply an early or favourable termination of the disease. 5. The type of the seizures. The greatest difference in the proportion of cases with and without stigmata was observed in those which presented the combined *grand* and *petit mal* type. Such combination had also been shown to be associated with the highest grades of dementia. The purely petit mal type did not exhibit marked evidence of hereditary degenerative disposition. 6. The relation between the presence of stigmata and *the mental state* was especially obvious. Those epileptics who only showed the slighter degrees of mental impairment presented a nearly equal proportion with and without stigmata (21 per cent. with and 19 per cent. without). On the other hand, of those in whom there was marked mental enfeeblement 53 per cent. exhibited, and only 7 per cent. were free from, them. Hence there would appear to be a close association between degrees of mental impairment and the presence of neuropathic stigmata, a fact which was proffered as an argument in favour of the view that the interparoxysmal mental condition in epilepsy was an integral part of the disease.—Dr. C. H. BOND stated that although the epileptics in his charge at the Ewell colony were under the Lunacy Act his statistics on the questions under discussion bore a strong resemblance to those of Dr. Turner. He thought that additional value would be given to such statistics by mentioning the ages of the patients at which the various stigmata had been observed. An important advance would be made when congenital and acquired conditions of idiocy were separately dealt with.—Mr. STEPHEN PAGET asked whether the stigmata mentioned were related especially to epilepsy or were general in neuropathic conditions and what essential difference there was between the appearance of such malformations as had been referred to and the antenatal factors which lay behind variations in height and stature. He believed a certain amount of asymmetry to be general and the presence of badly formed palates and jaws almost universal in the London poor.—Dr. G. E. SHUTTLEWORTH thought that the presence of a single stigma was of little importance but the combination of two or three or more was certainly an evidence of degeneration. He agreed that the percentage of developmental defects was much greater in males than in females but that when they did occur in the latter they were likely to be strongly marked.—Dr. FLETCHER BEACH asked for Dr. Turner's experience of cranial abnormalities such as microcephalus, hydrocephalus, and changes in the skull as the result of paralysis. Had any cases of webbed fingers been noticed in the series of cases?

Dr. A. E. GARROD and Dr. LL. WYNNE DAVIES communicated a paper on a Group of Associated Malformations, including almost Complete Absence of the Muscles of the Abdominal Wall and Anomalies of the Genito-urinary Apparatus. Dr. Garrod and Dr. Davies described in detail the clinical features and the post-mortem appearances observed in the case of a male infant which presented a malformation-complex such as had been described in a few other cases which had come under observation in this country, in America, and on the continent of Europe. These cases had been collected and discussed by Stumme of Leipsic in a very complete monograph published in 1903. The deformities in question, which were evidently inter-related, included:—(1) Almost complete absence of the muscles of the abdominal walls; (2) hypertrophy and dilatation of the urinary bladder which had in most instances been attached to the umbilicus either directly or by a urachus; (3) a linear scar-like umbilicus; and (4) undescended testicles. In several cases, as in the one here described, there had been deep furrowing of the skin of the abdomen. Owing to the absence of

muscles the abdominal viscera could be felt with very remarkable distinctness. Some other deformities were present in this case, such as double talipes varus. The child died from broncho-pneumonia and erysipelas and Dr. Garrod and Dr. Davies were able to include a report by Dr. F. E. Batten on the microscopical appearances of the vestiges of muscular substance in the abdominal walls and upon the condition of the spinal cord of the patient. The spinal cord had not been examined in any previous fatal case and a gap in their knowledge was thus filled in. The possibility that the condition of the muscles was due to intra-uterine poliomyelitis was excluded by Dr. Batten's report. Brief abstracts were included of the few similar cases hitherto recorded and the resemblances between them and the differences which they presented were discussed. Dr. Garrod and Dr. Davies favoured the view which was advocated by Stumme in his monograph that of the three possible theories—viz.: (1) that the condition of the bladder is due to the non-development or atrophy of the muscles; (2) that the two malformations have a common cause; or (3) that the non-development or atrophy of the muscles is secondary to a temporary obstruction of the escape of urine occurring during intra-uterine life—the last was the most likely to be correct. No existing obstruction was found in any case, but the distension of the bladder, and in some cases of the ureters also, suggested that such had existed at some period. As all the cases hitherto observed had been in males it was tempting to ascribe the supposed obstruction to a kinking or constriction of the penis, but it might be that, as Stumme suggested, the attachment of the bladder to the umbilicus was the primary cause. However, such attachment had not been invariably present, even in cases in which the navel had the characteristic slit-like form. Dr. Batten considered that the microscopical appearance of the vestiges of muscles in the abdominal walls pointed to non-development and not to atrophy of originally developed muscles. Stumme ascribed the non-descent of the testicles to occlusion of the inguinal canals by intra-abdominal pressure.—The PRESIDENT emphasised the importance of the paper and of putting on record every case of the kind, as they evidently belonged to a well-defined symptom-complex.—Dr. L. G. GUTHRIE preferred to believe that the condition owed its origin to a primary non-development of the abdominal muscles and explained how such a condition would give rise to hypertrophy of the bladder wall and other anomalies. He believed that the attachment of the urachus to the anterior abdominal wall might give rise mechanically to obstruction of the ureters and thus to their overgrowth. There was no direct evidence of any temporary obstruction to the escape of urine during intra-uterine life and such a condition would have to operate a very long time to bring about the muscular atrophy found in these cases, even if that was the natural result.—Dr. E. FARQUHAR BUZZARD was incline to agree with Dr. Guthrie and supported the view that arrested development of the abdominal muscles might be held to explain the other abnormalities in these cases. Before hypertrophy of the bladder had time to arise dilatation of the bladder and ureters would take place owing to the accumulation of secretion which was not properly expelled in the absence of abdominal muscular contraction. He cited other instances of congenital symmetrical absence of certain muscles which he had observed.—Dr. G. NEWTON PITT asked whether the anterior or the posterior bladder wall was the more hypertrophied. In ordinary cases of chronic vesical enlargement the anterior wall was much thicker than the posterior; in the absence of the abdominal muscles he would expect the thickening to be general.—Dr. GARROD replied.

MEDICAL SOCIETY OF LONDON.

Exhibition of Cases.

A MEETING of this society was held on Feb. 13th, Mr. JOHN LANGTON, the President, being in the chair.

Dr. T. R. GLYNN showed a case simulating Intracranial Tumour in which there was spontaneous and persistent escape of cerebro-spinal fluid from the nose, with complete recovery. A man, aged 26 years, in August, 1898, received a blow on the vertex of the head which caused temporary loss of consciousness, headache, and vomiting, and compelled him to give up work. In a month's time the pain was paroxysmal and was associated with vomiting and dilatation of the pupils. Double vision was complained of within two months of the accident. His memory failed and he suffered from vertigo and choking sensations. On examination there was weakness of the left external rectus; the knee-jerks were exaggerated and the plantar reflexes were absent; the abdominal and cremasteric reflexes were less marked on the left than on the right side. Certain hysterical stigmata, left hemianalgesia, and concentric restriction of visual fields were also observed. Early in 1899 optic neuritis developed and he complained of giddiness when he stooped, with a tendency to fall forward. After some temporary improvement he gradually became worse and the deterioration continued until June, 1903, with progressive failure of intellect and of muscular power. His gait became reeling with some propulsion on going downhill. His arms were ataxic and presented volitional tremors. His sight almost completely failed and nystagmus was noted. The superficial reflexes were absent and ankle clonus was present. During 1903 he had several epileptic attacks and suffered from incontinence of urine. In June, 1903, clear fluid commenced to flow from the right nostril and very soon improvement set in, followed by complete recovery in the course of a few weeks.—Dr. E. E. GLYNN explained with the aid of a diagram how the symptoms may have been due to internal hydrocephalus and may have been relieved by spontaneous drainage of the fluid from the distended lateral or third ventricle along the perineural sheaths of the olfactory nerves and so into the nasal cavity.—Dr. STCLAIR THOMSON said that the case supported his theory that spontaneous rhinorrhœa of cerebro-spinal fluid was always the result of internal hydrocephalus. He believed that the fluid escaped directly into the roof of the nose and not into the accessory cavities. Many patients with cerebro-spinal rhinorrhœa died from meningitis.

Mr. W. BRUCE CLARKE showed a case of Cancer of the Stomach one year after pylorectomy. A man, aged 59 years, was admitted into St. Bartholomew's Hospital on Jan. 9th, 1904, suffering from symptoms of cancer of the stomach. The abdomen was opened a fortnight later and the stomach, which was much thickened at the pyloric end, was found to be adherent to surrounding parts. No glands could be felt. The stomach was cut across about two and a half or three inches from the pylorus and about one inch of the duodenum was removed at the same time. Openings in the stomach and duodenum were reduced to the same size and united end to end. The patient made an uneventful recovery and was able to go to a convalescent home about a month later. An examination of the growth showed that the bulk of it was non-malignant in character and was due to the thickening which had occurred around an old ulcer. Close to the pylorus was a small patch of malignant ulceration showing columnar-celled characters. He thought that the case afforded direct evidence of a benign growth in the stomach becoming malignant. There was no sign of any recurrence of the disease.—Dr. E. SYMES-THOMPSON cited another case where the character of the lesion suggested a primary innocent with a secondary malignant condition.—Dr. A. F. VOELCKER asked whether the patient had been tested for free hydrochloric acid in the stomach before operation.—Dr. F. J. POYNTON thought that it was impossible to tell clinically in many cases whether disease of the stomach was innocent or malignant and he agreed that ulceration in the region of the pylorus produced symptoms out of proportion to its extent, whereas large diseased areas nearer the cardiac orifice were often unsuspected before a necropsy revealed their presence.

Mr. BRUCE CLARKE also showed a case of Oöphorectomy for Cancer of the Breast five years after operation. In 1890 a woman, aged 46 years, noticed a small lump in her breast and five years later blood-stained discharge from the nipple. In April, 1897, there were two lumps in the breast and Halstead's operation was performed. Two or three more operations were performed for glands above the clavicle but abundant recurrence took place accompanied by much pain in the neck and the arm. In March, 1900, double oöphorectomy was performed. Within 48 hours the pain ceased and before she left the hospital a month later the skin growth had begun to shrivel. This continued for two months, when she reached her present condition. With the exception of occasional attacks of pain she had remained well and was able to do all her ordinary household work.

Mr. H. J. WARING showed a case of Double Oöphorectomy for Carcinoma of the Breast. A single woman, aged 37 years, came under observation in September, 1904, when she was found to have a large carcinomatous growth of the

right breast which had first been noticed about two years previously. Ulceration of the skin had begun about two weeks before coming under observation. The growth involved the whole mammary gland as well as the underlying muscles and was firmly fixed to the chest wall. Enlarged axillary glands were also present. Double oöphorectomy was performed on Sept. 27th and the patient made a rapid recovery. When discharged a month later the tumour had diminished in size and the general condition of the patient had improved. Since then little change had taken place, although the lymphatic glands in the axilla seemed to be a little smaller.—Mr. A. CARLESS stated that he had performed oöphorectomy in 12 cases of mammary scirrhus and had always found that pain was relieved, that the growth and the glands diminished in size, and that the patients were often able to go about their ordinary work for two or three years in comparative comfort. He advocated complete removal of all growth at the same time as oöphorectomy.

Dr. POYNTON showed two cases of Exophthalmic Goitre. 1. The patient was a man, aged 33 years, who had noticed for four months that his right eye was more prominent than his left. He was very nervous and suffered from palpitation and sweating after exertion. The thyroid was slightly enlarged and there was some fine tremor of the hands. The heart was not rapid at rest but was easily excited. No local cause for the proptosis could be discovered. 2. The patient was a boy, aged nine and a half years, who had recently become exceptionally nervous and had been taken to the Hospital for Sick Children on account of swelling of the thyroid. Persistent tachycardia was noticed with the occasional presence of von Graefe's sign. There was some coarse but no fine tremor of the hands.—Mr. A. THORNE asked whether there was any explanation of the unilateral character of the proptosis.

Dr. J. BRUNTON exhibited a case of Aneurysm of the Descending Arch of the Aorta appearing externally to the Left of the Spinal Column. A man, aged 43 years, had complained of pain over the left side of the thorax for 12 months. Early in December, 1904, a swelling was noticed between the vertebral border of the left scapula and the spinal column and this had increased in size. On auscultation a soft bruit could be heard over the pulsating area during both expansion and recoil. There was no abnormal pulsation in front, the second aortic sound was accentuated, and both the respiratory murmur and movements were diminished on the left side of the chest. There was no dysphagia, laryngeal symptom, or inequality of pupils. Arterial degeneration was not marked. A skiagram had not given substantial help to the diagnosis. —Dr. H. E. BRUCE PORTER inquired whether it was possible for an aneurysm to bulge so much without giving rise to pressure symptoms.—Dr. C. O. HAWTHORNE did not think that the case was one of aneurysm as he had never seen one where the ribs were so eroded in the absence of other evidence of pressure.

Dr. W. EWART showed two cases of Diabetes. 1. A man, aged 26 years, was admitted into St. George's Hospital with a history of a few weeks' rapid loss of flesh and strength with polydipsia and with symptoms of threatening coma and strong acetonæmic smell. The urgent symptoms were quickly relieved by large doses of sodium bicarbonate (up to six drachms three times a day) and by dieting. The urine remained acid until Feb. 5th when the dose of sodium bicarbonate was reduced to four drachms, the acid reaction then returning. At present he was having five drachms of sodium bicarbonate, 30 grains of hypophosphites, and 20 minims of liquor strychninæ three times daily. His diet restrictions were not absolute and his progress was satisfactory, there being only a faint smell of acetone in the breath. He passed about three and a half pints of urine daily of specific gravity 1030. 2. A man, aged 24 years, was admitted for polydipsia and weakness of three weeks' standing. The condition was possibly due to excessive consumption of jams, marmalade, and starchy food. His weight was 9 stones 7 pounds; he was passing about five pints of urine daily of specific gravity 1040, and the percentage of sugar was 8·5. He improved rapidly under restricted diet, the sugar disappearing altogether for six days. With the exception of the sodium bicarbonate he had had the same treatment as the first patient and his present weight was 10 stones 4 ounces. He was passing three and a quarter pints of urine daily of specific gravity 1030.

Dr. W. ESSEX WYNTER showed a case of Tumour of the Left Lobe of the Cerebellum. The patient, aged 36 years, was laid up with vomiting and constipation in July, 1904. He recovered from this but in August noticed that he became easily fatigued and was told that he walked as if intoxicated. Left facial palsy and deafness in the left ear came on about this time. In September the right leg became too weak and unsteady to bear his weight but he was able to walk with a stick when first seen in January, 1905. Now the gait was partly spastic and partly ataxic; there was complete left facial palsy and complete nerve deafness of the left side. He complained of some vertigo and occipital headache and presented nystagmus and dilatation of the left pupil. The deep reflexes were brisk and there was double extensor response. The optic discs were pink, with vessels full, but there was no definite neuritis.

CLINICAL SOCIETY OF LONDON.

A Case of "Soft-valve" Mitral Stenosis without Murmur.—A Case of Accessory Thyroid laterally placed in the Floor of the Mouth.—Extraperitoneal Uretero-lithotomy in a Child, aged three years.—Calculous Anuria in a Child, aged four years.

A MEETING of this society was held on Feb. 10th, Dr. FREDERICK TAYLOR, the President, being in the chair.

Dr. W. EWART recorded a case of "Soft-valve" Mitral Stenosis in which no murmur was heard. The patient, a woman, aged 45 years, was under observation for two months before death and during that time no suspicion of the existence of mitral stenosis was aroused and no diastolic murmur was heard. At the necropsy considerable narrowing of the mitral orifice was present but the valve, the chordæ tendineæ, and the musculi papillares showed very little induration. The heart was enlarged, the muscle was flabby, and the other valves were competent. The clinical value of the case lay in the undoubted character of the lesion and in the independent testimony of various observers, during a long period of hospital treatment, as to the absence of murmurs, demonstrating the fact that the characteristic bruits may sometimes be in abeyance for prolonged periods at an advanced stage, though more often in abeyance for short intervals only at an early stage. The anatomical features of the lesion, of special interest in connexion with this latency, were fairly described by the term "soft-valve stenosis," which might be of use in defining a separate type of lesion in which the early fibrous changes did not, as in the "hard-valve stenosis," develop into progressive thickenings and indurations. The action of a relatively soft stenosed mitral valve must be different from that of the rigid stenosis, particularly when, as in this instance, the chordæ tendineæ and the papillary muscles were quite free from stiffness, shortening, or fibrosis. The absence of murmur where this complication was also absent might perhaps, if observed in other cases, be an argument in support of the prevalent view as to the auriculo-systolic mode of production of the presystolic mitral murmur and as to the share taken by damaged chordæ in occasioning diastolic murmurs.—Dr. SEYMOUR TAYLOR said that he regarded the absence of the proper auricular driving force as the essential factor in the disappearance of a presystolic mitral murmur and suggested that it was the cause in Dr. Ewart's case. He did not think that the softness of the valve alone would explain the absence of bruit. With regard to the causation of mitral stenosis he was of opinion that in the majority of cases the valvulitis was the result of rheumatism or chorea before puberty, in consequence of which the diseased valve did not keep pace with the development of the rest of the organ. After puberty mitral endocarditis more commonly gave rise to incompetence and rarely to stenosis.—Dr. F. PARKES WEBER mentioned a case of mitral stenosis with the ring partially calcified, in which the presystolic murmur had disappeared during cardiac failure.—Dr. W. PASTEUR asked whether Dr. Ewart had noticed any alteration in rhythm or in the character of the first sound suggestive of narrowing of the mitral orifice.—Dr. W. ESSEX WYNTER thought that the thinness and the yielding character of the valve were of particular interest and might have contributed to the absence of murmur. In his experience mitral stenosis was not found in children under seven and rarely in children between seven and 14 years of age. He agreed with Dr. Seymour Taylor that the

continuance of the infantile type of valve owing to disease in early life was often the cause of mitral stenosis. The history of rheumatism was often difficult to obtain on account of the slight character of the symptoms and the absence of arthritis in children.—Dr. F. H. HAWKINS mentioned the case of a woman, 56 years of age, who was under observation for a month before death and had no cardiac murmur. Post mortem there were mitral stenosis and thrombosis of the abdominal aorta and its branches.—The PRESIDENT agreed with Dr. Seymour Taylor that the character of the valve was not sufficient to explain the absence of bruits and pointed out that the left auricle was free from evidence of hypertrophy.

Mr. E. PERCY PATON recorded a case of Accessory Thyroid in the Floor of the Mouth. A girl, aged 16 years, noticed a swelling on the right side of her neck in the submaxillary region for some months before coming under observation. It gave her no pain but she was certain that it was increasing in size. It was situated in the right submaxillary triangle and could be felt from inside as well as from outside the mouth. The diagnosis before operation was uncertain but on microscopical examination after removal it was shown to consist of thyroid tissue. In studying the literature of accessory thyroids he had been unable to trace any similar case.—Mr. W. G. SPENCER showed an illustration from a paper by Wilhelm His on the Development of the Thyro-glossal Duct which, he thought, explained the presence of thyroid tissue in the situation where it was found by Mr. Paton.

Mr. H. BETHAM ROBINSON described a case of Extraperitoneal Uretero-lithotomy in a child, aged three years. The child upon whom this operation was performed was admitted to the East London Hospital for Children on June 17th, 1904, with an impacted calculus in the urethra. On examination, after this stone had been extracted, there was felt bimanually a small hard lump on the left side of the pelvis just below its brim which was diagnosed as an impacted calculus in the ureter; the corresponding kidney did not appear to be enlarged. After waiting a few days for the urethral wound to heal and to see whether the stone was making its way to the bladder, which it did not do, he performed uretero-lithotomy and removed a small oval calculus. A fine catgut stitch was put through the outer part of the ureter and a wick drain was left in the wound down to it. The rest of the wound was sewn up with horsehair. There was very slight leaking for three days; after that the wound healed rapidly. There was no blood in the urine after the operation. From an experience of three cases, two in the adult and this child, he considered the operation easier in the child for the following reasons: the small quantity of fat in the abdominal wall and subperitoneal connective tissue and the shallow pelvis with the abdominal position of the bladder. The latter enabled the finger in the rectum to push the ureter with the impacted stone well up into the wound.

Mr. DOUGLAS DREW read the notes of a case of Calculous Anuria in a child. A boy, aged four years, was admitted into hospital with stone in the bladder and cystitis for which suprapubic cystotomy was performed and the bladder was drained. After the operation the child did not make good progress. The pus persisted in the urine, there were occasional rises of temperature, and the wound above the pubes did not completely heal. The child occasionally complained of pain in the abdomen but nothing definite was found after repeated examinations except slight tenderness over the left kidney. This symptom, together with the persistence of the pyuria and irregular attacks of temperature, led to the diagnosis of septic trouble in the left kidney. At the end of four months the child was seized with severe pain and a stone was found impacted in the meatus and was removed. After this marked improvement occurred, the sinus above the pubes closed, the temperature kept normal, and the condition of the urine greatly improved. A month later the child began to vomit, pain recurred in the abdomen, the urine again became alkaline and contained pus and blood, and the wound above the pubes again began to leak. At the same time the quantity of urine, which had been measured daily, diminished from 25 ounces to between seven and 19 ounces. Two radiographs taken at intervals of a few days about this date gave negative results. A few days later the abdominal pain became more severe and for the first time was referred to the left inguinal region. Examination under chloroform showed that the left kidney was enlarged and that the right was of normal size. Per rectum a stone of triangular shape was felt in the left ureter just below the brim of the pelvis. The left kidney was at once exposed and a calculus was found and removed from it; the wound was extended forwards and the calculus in the ureter was manipulated up along it and removed through an incision just below the pelvis. The right ureter could be distinctly felt through the wound and was enlarged; this was the first positive sign of trouble on the right side, as the stone which was found post mortem in the lower end of the right ureter had been missed on palpation per rectum, and there had been no symptoms referred to the right side. The child's condition did not permit of exploring the right kidney at the time the stones were removed from the left side, and although he lived six days after the operation the condition did not improve sufficiently for any further interference. The vomiting persisted, drowsiness increased, and the quantity of urine per urethram gradually diminished, only two and a half ounces being passed during the last three days. The chief point of interest was the difficulty in diagnosis, owing to the negative results of radiography and the very slight degree of pain occasioned by the stones. The case was extraordinary in that calculi were removed from the bladder, the urethra, and the left ureter and kidney.—Mr. PATON referred to a death from unsuspected calculous anuria in a child who had been operated on for cleft palate. There had been no urinary symptoms previous to the operation.

OPHTHALMOLOGICAL SOCIETY.

Tobacco Amblyopia.—Neuro-fibroma of the Eyeball and its Appendages.—Exostosis of the Orbit.

AN ordinary meeting of this society was held on Feb. 9th, Mr. JOHN TWEEDY, the President, being in the chair.

Mr. C. WRAY (Croydon) read a paper on Tobacco Amblyopia. He divided cases of tobacco poisoning as seen in ophthalmic practice into three categories: (1) those with toxic amblyopia; (2) those with amblyopia and tachycardia; and (3) those with tachycardia alone. He contended that in view of the tendency to cardiac failure in various febrile conditions ophthalmic surgeons as a matter of routine should examine the pulse. During the last eight weeks several cases of toxic amblyopia had come under his notice at the Western Ophthalmic Hospital and the Croydon General Hospital, in which the pulse was 96, 84, 135, and 96 to 120. Such cases proved that patients with defective sight due to tobacco should be warned that tachycardia might come on without any such peremptory warning as defective sight. He then asked: Does giving up tobacco entirely cure amblyopia and tachycardia? and stated that the amblyopia usually disappeared if taken early but in all cases the convalescence under recognised treatment was very protracted and occupied many weeks. As regarded the tachycardia it was not easy to make a positive statement but in several cases which he quoted the tachycardia had not disappeared after tobacco had been given up for several years. He alluded to toxic breath and stated that although it was probably always present with toxic amblyopia it was never present when tachycardia existed as the sole manifestation of the poison and he was inclined to think that tachycardia was due to injury or destruction of the cardio-inhibitory neurons in the trachea and bronchi. The amblyopia, he believed, was due to saturation of the blood with tobacco alkaloids and he would explain the relative frequency of amblyopia as a toxic manifestation by the accuracy with which we could gauge the physiological condition of the papillo-macular neurons. He suggested as an explanation of poisoning in some cases and not in others that this was not so much due to idiosyncrasy as to the accident of bad teeth so common in heavy pipe-smokers and so fatal in phosphorus workers, possibly also, and indeed probably, to the condition of the mucous membranes of the alimentary and respiratory tract, in harmony with the rule that when the epithelium was absent or defective substances were more readily absorbed as the poisons were brought into intimate contact with the capillaries. Mr. Wray then went on to say that for some time he had abandoned the orthodox treatment by strychnine and potassium iodide as the results were uniformly unsatisfactory. He then pointed out that nicotine was used to paralyse "ganglion cells" and it was precisely the ganglion cells that suffered in the retina. In the circumstances it seemed justifiable to infer that nicotine was

the hypothetical cause of amblyopia and, since that alkaloid was freely soluble in water, that not improbably water might be made to aid in the elimination of the poison. With that object in view his patients were directed to dress warmly and to drink one pint of warm water at 7 A.M. and to walk briskly for 30 minutes in the open air; then to drink a second pint and to walk briskly in the open air for another 30 minutes, after which to rest for a few minutes and then to take breakfast. A third pint should be taken in the middle of the morning and a fourth in the middle of the afternoon. Some of the patients during convalescence smoked a quarter of an ounce of tobacco a day and in three cases practically normal vision was secured in about 14 days, whilst according to some of his notes patients under the strychnine treatment were as long as 12 weeks in obtaining an equally good result. As regarded the effect of the water treatment on tachycardia, he had not had an opportunity of trying it as the new cases of amblyopia that had come under his treatment during the last eight weeks had only a very slight acceleration of the pulse-rate but unquestionably it had not disappeared in the same way as the amblyopia. He thought that there was considerable doubt as to the method of elimination of nicotine. It was excreted by the kidneys, the lungs, and the skin; he thought mostly by the kidneys, others by the breath, and others by the skin, but the water treatment had this advantage, that it utilised all three methods.

Mr. E. TREACHER COLLINS and Dr. RAYNER D. BATTEN communicated a paper on Neuro-fibroma of the Eyeball and its Appendages. The case which formed the basis of this paper was that of a girl, aged 14 years, who had been under Dr. Batten's observation since January, 1902. Her right eye was buphthalmic. The cornea was large and hazy and the anterior chamber was very deep. The vision equalled $\frac{1}{60}$. There was also marked hypertrophy of the upper eyelid, the skin of which was coarse and thickened, and there was a soft doughy swelling over the right temporal fossa. The condition dated from birth. The eye being very unsightly and irritable was excised, as was also a wedge-shaped piece of the thickened upper lid. Microscopical examination of the latter showed extensive overgrowth of the fibrous tissue of the corium and marked enlargement of the nerves due to thickening of their peri- and endo-neurium. The condition was evidently one of congenital elephantiasis associated with plexiform neuroma, a condition to which the convenient term neuro-fibromatosis was applied. The chief interest of the case consisted in the condition of the eye. This made the fourth case which had been recorded in which neuro-fibromatosis of the eyelid had been associated with a buphthalmic condition of the eye. The buphthalmic condition of the eye did not, however, seem to be due directly to fibromatosis of the ciliary nerves but to increased tension from obstruction to the exit of fluid. In the present case and another one which Mr. Collins had examined he found congenital adhesion of the root of the iris to the back of the cornea blocking the filtration area. The terminal filaments of the nerves in the cornea were, however, found thickened; they could be seen by the naked eye as grey lines and microscopically as cords of elongated cells. The condition of the choroid in this case was most remarkable and presented appearances which did not seem to have been described previously. Throughout its structure was denser than normal and in parts it was considerably thickened. Microscopically the blood-vessels in it were few and inconspicuous. It was composed of fibrous tissue arranged in layers, highly nucleated, and with many pigmented cells between them. In some places there were numerous small oval bodies which presented the appearance of enlarged nerve-end organs. In conclusion, by a comparison of this case with the few others recorded it was shown that all portions of the ciliary nerves supplying the eye might be affected by this congenital fibromatosis and that in the uveal tract, as in the skin, associated with the neuro-fibromatosis there might be a general hyperplasia of the fibrous tissue of the part. The extent, however, of the affection varied in its distribution, sometimes being confined to one set of ciliary nerves and the part supplied by them and sometimes to another. In some cases only the terminal filaments and end organs of the nerves were involved and in others the larger trunks were also affected.

Mr. A. OGILVY (Bristol) reported a case of Large Exostosis removed from the Orbit. The patient was a healthy man, aged 24 years. There was no previous history of any ailments and there was a healthy family history. The patient was first seen last November; he did not know there was anything in his orbit—he merely came because of epiphora. A large hard mass was felt in the right orbit, evidently growing from the nasal side. Skiagraphs were made showing well the extent of the tumour which was evidently causing myopia and some form of choroidal change. The operation was performed on Jan. 1st, 1905. Great difficulty was experienced in removing the tumour which, however, proved to be pedunculated and measured over an inch in each direction. Recovery after operation was rapid, union being by first intention. The only trouble was diplopia, caused by complete immobility of all the muscles; this passed off in a fortnight.

Mr. EDGAR STEVENSON also described a case of Exostosis of the Orbit. The patient, a girl, aged 22 years, went to the Liverpool Eye and Ear Infirmary on Nov. 20th last with well-marked downward and outward proptosis of the left eye. She stated that the prominence of the eye had been first noticed six months previously and that it was rather rapidly increasing. She had no pain except an occasional neuralgic twinge, the movements of the eye were quite free, and she was not troubled with diplopia. Her vision in each eye was normal with correcting glasses, as also was the fundus of each eye. Digital examination under chloroform revealed a small hard mass lying under the outer and upper margin of the orbit. Three weeks later Mr. Stevenson decided to operate and on Dec. 10th the patient was again put under chloroform and the tumour was exposed. It was found that the growth was much larger than was to be expected from the previous examination. It seemed to be attached to the inner angle of the orbit with its base in the frontal sinus and to extend right across the roof of the orbit. Two attempts to drill through the more prominent part failed on account of the drills breaking and Mr. Stevenson then attempted to chisel through the frontal sinus in order to expose the base. A small part of the tumour here became detached and showed cancellous structure underneath a hard outer shell. There appeared to be some "shake" in the tumour during the chiselling which seemed to indicate that the point of attachment was not very large, so having ascertained that there was not any apparent involvement of the roof of the orbit the tumour was seized with a pair of bone forceps and wrenched out without difficulty. It was of irregular pear shape, weighed 351 grains, and its dimensions were one and a half inches by one and three-eighths inches by seven-eighths of an inch. The patient made an uninterrupted recovery and her vision, muscular balance, and ophthalmoscopic appearances are normal.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

Paratyphoid Fever.—Large White Kidney.

A MEETING of this section was held on Jan. 20th, Sir J. W. MOORE being in the chair.

Dr. A. R. PARSONS read notes on three cases of continued fever in which for some time the diagnosis was obscure. They all occurred in the same building and at about the same time. The first proved to be a severe case of typhoid fever and gave a definite Widal reaction with Eberth's bacillus typhosus on the twelfth day of the illness. The pyrexia lasted for 50 days. The second case, though tested on three separate occasions by different strains of bacillus typhosus, gave no reaction but gave very definite clumping with Gärtner's bacillus enteritidis on two occasions and with different strains. The pyrexia lasted for 21 days. Case 3 was also negative with bacillus typhosus but positive with Gärtner's bacillus. The pyrexia lasted for 14 days. In all the cases the subjective phenomena were headache and malaise. The objective signs were temperatures of from 102° to 104° F., while the average pulse rate was only 90. In none of the cases was the spleen palpable and only in the first case were any spots visible. Cultures were made from the urine and fæces in the latter cases but the bacillus enteritidis was not isolated. Dr. Parsons referred to cases of paratyphoid fever reported in the *American Journal of the Medical Sciences* and pointed out the necessity for isolating various strains of the bacilli of paratyphoid fever against which the blood of obscure cases

of continued pyrexia might be tested. Owing to the general absence of ulceration in paratyphoid fever he was of opinion that the diet need not be quite so strictly regulated as in typhoid fever.—Dr. J. CRAIG described minutely the fatal case of paratyphoid fever which he had seen. The patient was a man whose appearance suggested typhoid fever. His temperature was 103·2° F. and his pulse and respirations were 100 and 24 per minute respectively. He had three liquid yellow motions and developed a rash which at first consisted of rose spots but later became dark, like that of typhus fever. The tongue was thickly coated, the cerebration was slow, and he refused food. The abdomen was distended. He became delirious and 17 days after the rigor which had ushered in the illness he died. The pulse averaged from 95 to 100 and the respirations 24 per minute respectively. The spleen was easily seen to be enlarged. At the necropsy no evidence of enlargement or ulceration of Peyer's patches was found but the greater part of the ileum was in a state of acute inflammation. Dr. White examined the blood on the fourth day after admission. He tried a Widal reaction and obtained clumping with a dilution of 1 in 25. There was no evidence of Eberth's bacillus but one of the forms of bacillus enteritidis had caused the illness. In a number of cases hæmorrhage from the bowel had been observed.—Dr. R. TRAVERS SMITH said he had seen two cases which he thought were paratyphoid fever. One of them was a woman, aged 32 years. On admission to hospital her temperature was 103° F., her pulse was not markedly quick, there was no diarrhœa or enlarged spleen, and there were no rose spots, but there was great abdominal distension and she was rather livid. The blood was negative to Widal's reaction. She died in about a week and at the necropsy not a trace of disease was found in Peyer's patches, neither was the spleen enlarged. In the other case the tongue was coated, the spleen was a little enlarged, the pulse was rather quick, and the temperature was raised. The blood was negative to Widal's reaction. The fever gradually subsided but for ten days the spleen remained large, then it subsided, and she got perfectly well. He suspected paratyphoid fever but had no proof of it, as the special blood reaction had not been tested for.—Dr. G. E. P. MELDON thought that in paratyphoid fever the diet ought to be regulated as carefully as in typhoid fever, for in some cases there had been hæmorrhages showing disease of the intestine. The presence of a large ulcer had been reported in one case.—Dr. E. M. FANNIN said that he once had under his care a youth, aged 17 years, who suffered from a continued fever the characters and course of which were the same as those of typhoid fever. There were no rose spots and no enlargement of the spleen but there was acute laryngitis. At that time the Widal reaction was negative. Ten days after the temperature had become normal a relapse occurred. It presented the features of typhoid fever, the laryngeal symptoms were renewed, rose spots appeared, and the spleen became palpable. The patient became very ill and was removed to hospital. Two or three days afterwards symptoms of perforation occurred. An operation was performed and a perforated ulcer was discovered. The patient did not recover. Dr. Thompson was satisfied that the ulcer was like an ordinary typhoid one. In that case, then, repeated examinations of the blood had failed to give the Widal reaction. The course of the illness resembled typhoid fever and a fatal result occurred after perforation, therefore it was possible that some forms of paratyphoid fever could have the definite ulceration of Peyer's patches.—Dr. KIRKPATRICK said that he would like to ask whether any differentiation had been made in the clinical history of the fevers which were due to the different groups of paratyphoid bacilli.—Professor E. J. MCWEENEY discussed the cases from a pathological point of view. He said that he would be inclined to describe Dr. Parsons's second and third cases as cases of infection with Gärtner's bacillus. It had been mentioned that the blood serum failed to agglutinate cultures of the typhoid bacillus but agglutinated cultures of Gärtner's bacillus. That carried an indication of infection with Gärtner's bacillus which was not quite the same thing as paratyphoid fever. Gärtner's bacillus was not quite the same type as the alpha and beta groups of paratyphoid bacilli but presented certain differences. It was quite possible that the second and third cases were paratyphoid fever but the bacilli would have had to be isolated and their characters fully tested. What he found lacking in the pathological description was a statement of the different dilutions which were employed.—Dr. PARSONS, in the course of his reply, said that intestinal lesions had been mostly found to be in abeyance during paratyphoid fever and he thought that in it restriction of the patient's diet was not so necessary as in typhoid fever. There was no difference in the clinical course of the fevers produced by the alpha and beta groups. In his communication he had used the term paratyphoid in its widest sense and included Gärtner's bacillus in the term, although he was aware that there was a tendency to restrict the term to a small group of bacilli.

Dr. G. PEACOCKE described the clinical history of two cases of Large White Kidney which had been recently under his care. The symptoms of each case were very similar and were briefly anæmia, universal dropsy, diarrhœa, and scanty, highly albuminous urine containing numerous casts.—Professor MCWEENEY, Dr. TRAVERS SMITH, and others took part in the ensuing discussion.

BRITISH GYNÆCOLOGICAL SOCIETY.—A meeting of this society was held on Feb. 9th, Dr. William Alexander, the President, being in the chair.—Dr. H. Macnaughton-Jones read notes of a case of Ascites with Pelvic Symptoms which proved to be due to a typical fibroma of the left ovary; the tube was not involved and the adnexa on the opposite side were healthy.—Dr. Macnaughton-Jones also read notes of a case of Carcinoma of the Ovary in which there had been neither pain nor any evidence of malignancy up to within six weeks of the operation which was undertaken for parametritis and peritonitis. The tumour (exhibited) was adherent to a myomatous uterus in front and to the intestine and rectum behind; neither tube was involved, nor the other ovary. There was no ascites.—After the discussion on these specimens the President delivered his Inaugural Address, embodying his own experience of the rise and progress of gynæcology. When he was a student there was no gynæcology worthy of the name. The abdomen belonged to the physician and "inflammation" was a name which included many diseases which were now treated successfully by the surgeon or the gynæcologist. Abdominal tumours were, in the first instance, referred to the physician and only when medical measures failed was the case handed over to the operator. Whilst the physician treated all the internal diseases of the abdomen the obstetrician repaired any damage caused by parturition. But the obstetricians had but small experience in surgery and did not often care to undertake it and so these cases passed into the hands of the general surgeon. Gynæcology afterwards learned from medicine the mutual action of the genital organs and the rest of the system; from obstetrics the changes due to pregnancy; but it was to surgery that the greatest advances of the past 50 years were due. Surgery and gynæcology had so much in common that a knowledge of the former was necessary for the successful practice of the latter. The earlier gynæcologists were not surgeons but were experts in the application of pessaries and many were remembered owing to the instruments bearing their names. No examination was considered complete without the use of sound and speculum, instruments which bimanual palpation had rendered obsolete save for some specific purpose. One of the most serious operations of that day was perineorrhaphy, as shown in a report of 12 cases with two deaths. Abdominal operations were rarely performed and generally ended fatally. Yet the surgery was excellent and some operators, by instinctive surgical cleanliness, obtained much success. There was, however, no guide until Lister enunciated the germ theory of disease. The extensive use of carbolic acid followed and worked wonders in general surgery. In 1877, when Lister came to London, Spencer Wells had reduced his mortality from 25·5 to 9 per cent.; with the carbolic spray he got still better results. Soon dissatisfaction was expressed at the irritation of the tissues caused by antiseptic dressings. Meanwhile bacteriology had developed and hence arose the aseptic system of treating wounds. It was asepsis which explained the success of Wells, Tait, Bantock, and other apostles of cleanliness, who, without admitting the germ theory, had unwittingly lighted upon the practice of aseptic surgery. This was the highest development of the germ theory and by no class of operators was it carried out more strictly or more successfully than by gynæcologists. To the patient aseptic surgery afforded greater comfort and safety, to the surgeon more certainty and greater success. The knowledge thus acquired once belonged to a few special men but had now become diffused throughout the country and aseptic

gynæcology was brought, as it were, to the doors of patients. He had been surprised at the excellence of the gynæcological as well as surgical work performed in small hospitals and the valuable assistance that could now be obtained in distant places from men whose surgical instincts were kept fresh and keen in such hospitals. There were other improvements which had accentuated the success of both antiseptic and aseptic gynæcology. Foremost amongst these was the Trendelenburg position in pelvic operations, then the avoidance of post-operative hernia by the methods of closing the abdominal wall, and the value of time in diminishing shock was well understood. Gynæcology still afforded an unexhausted field for future research and effort as long as the present high mortality of cancer of the uterus continued. Again, the nervous diseases of women required further study and the conditions, too often erroneously attributed to neurasthenia or hysteria, required to be classified and their treatment formulated. Their present treatment of uterine displacements could hardly be termed rational; it would not be tolerated in the displacements of other organs. The causes of many forms of displacement were involved in obscurity and urgently required elucidation.

THERAPEUTICAL SOCIETY.—A meeting of this society was held at the Apothecaries' Hall, London, E.C., on Jan. 24th.—Dr. W. E. Dixon (Cambridge) read a paper on the Action of Alcohol on the Heart. He said that alcohol was thought of by some as a stimulant, by others as a depressant, but substances such as thyroid extract, which produced little effect on health, might improve nutrition in disease. The action of alcohol was considered: (1) on the rate of the pulse; (2) on the heart itself; (3) on the blood-vessels; and (4) on the blood pressure. In small quantities and in a concentrated form it decidedly quickened the pulse at first but had no effect if it was much diluted; in very large doses it slowed the pulse. Its quickening action depended on its irritating effects on the mouth and stomach, like that of ammonia or even burnt feathers in fainting, but concentrated alcohol was more powerful than either. In too great a quantity it depressed the medulla. If chloroform was first given the stimulating effect was prevented. The heart was caused to contract more powerfully by alcohol at first though if much chloroform was first administered the heart became fatigued and did not respond to the stimulative power of alcohol. The internal vessels were constricted by the action of alcohol, as might be shown by the oncometer, the arm shrinking in bulk 15 or 20 minutes after it had been taken. This constriction drove the blood to the superficial vessels and caused the flushing of the face. Alcohol increased the blood pressure by stimulating the heart and constricting the vessels. Dr. Dixon summed up his remarks by saying that alcohol in small concentrated doses increased the rate of the pulse and the systole of the heart, constricted the deeper vessels, and increased the blood pressure, especially when the heart's action was feeble; it was therefore of great service in cases of fainting. If much diluted it had little effect on the heart but acted as a food, replacing starch in maintaining the heat of the body. In too large doses it depressed the heart.—Dr. H. A. Caley read a paper on Some Points in the Actions and Uses of Bismuth Salts, referring principally to the three insoluble salts in common use—the subnitrate, salicylate, and carbonate. Their local action on the stomach was first considered, their mechanical, astringent, and antiseptic properties were then discussed, and reasons were adduced for regarding the local action on the mucous membrane as the most important factor, their special usefulness in gastritis and ulcer being emphasised. Of the three, the carbonate was the most generally useful as a gastric sedative. In dealing with the action of bismuth salts in intestinal disorders Dr. Caley brought forward experimental evidence bearing on the antiseptic action of the three salts; the subnitrate had definite germicidal action on cultures of the bacillus coli, the salicylate a similar but much weaker effect, while the carbonate was inert as a germicide. Under laboratory conditions this antiseptic action of the first two salts was destroyed by alkalies; on the other hand, therapeutic experience showed that an alkaline medium did not destroy their efficacy. For this and other reasons it was inferred that the principal action of bismuth in the intestines was a local action on the mucous membrane and that the presence of catarrhal inflammation was one of the chief indications for its employment. If given in sufficiently large doses bismuth was potent in many intestinal disorders and was capable to a large extent of replacing the more direct intestinal antiseptics, strong astringents, and opiates. Of these three salts the subnitrate was the most efficacious in irritant lesions of the intestines and where a more marked astringent effect was desired he preferred a combination of this salt with catechu or other vegetable astringents to the more recently introduced subgallate of bismuth.

LIVERPOOL MEDICAL INSTITUTION.—A pathological meeting of this society was held on Feb. 9th, Dr. James Barr, the President, being in the chair.—Mr. W. Thelwall Thomas and Dr. E. Cleaton Roberts showed two specimens of Multiple Villous Growths of the Bladder removed from patients aged 56 and 60 years.—Mr. Thomas also showed two specimens of Volvulus. One was in a woman, aged 56 years, and included 15 inches of large and three inches of small intestine. The stump had a complete turn from left to right with a gangrenous convexity. The other was in a woman, aged 22 years, in whom 18 inches of gangrenous small intestine were removed. Specimens from a third abdominal case exhibited by Mr. Thomas showed the ovary and Fallopian tube to form the walls of an abscess cavity to which were attached four inches of gangrenous small intestine. These were resected and end-to-end anastomosis was performed.—Mr. J. Douglas-Crawford showed Microscopical Preparations of Actinomycosis from the jaw and from the skin.—Dr. R. J. M. Buchanan showed a Megasphere from a case of carcinoma of the lung.—Dr. Nathan Raw showed specimens of Primary Tuberculosis of the Kidney with Secondary Affection of the Bladder.—Dr. W. Blair Bell showed Radiographs (by Dr. C. Thurston Holland) of a case of Morton's Disease before and after treatment which consisted in the excision of the fourth metatarso-phalangeal joint and had resulted in complete cure.—Dr. Ernest E. Glynn showed a greatly Dilated Œsophagus from a man with symptoms of stomach disease; the necropsy showed, however, that the stomach was contracted and the cause of the dilatation remained obscure; there was no microscopical change in the musculature of the œsophagus.—Dr. Glynn also showed a Thrombosed Pulmonary Artery which had caused death in a boy a few hours after a perfectly successful operation for appendicitis.—Dr. A. W. Campbell read a note on Tuberose Sclerosis of the Brain, a very rare but well-defined condition consisting of a peculiar hard whitish appearance on certain areas of the cortex; these were not raised and did not infiltrate below the level of the immediate white matter. Microscopically they showed a glia structure and branched tubular glandular structures lined by columnar epithelium. Giant nerve cells were also seen. In the kidneys were myo-fibromata and on the skin soft tumours called adenoma sebaceum. The patient was an epileptic idiot, aged 27 years.—Dr. G. G. Stopford Taylor and Dr. F. H. Barendt spoke of having seen this condition of the skin in mentally defective persons and Mr. E. M. Stockdale and Dr. W. B. Warrington discussed the nature of the gland like structures.—Dr. C. Thurstan Holland read a note on the X Ray Diagnosis of Kidney Stones and showed a "Diaphragm Compressor" designed by himself. By the use of such a compressor the movements of the kidney during respiration were controlled, much sharper definition was obtained, and good negatives might be readily produced. By this method the negative diagnosis was made more sure—a point of very great importance. The note was illustrated by a series of lantern slides showing stones in the kidney. One slide showed an oxalate stone which when removed was found to weigh two grains, whilst another slide showed a uric acid calculus which weighed five grains.—Dr. Buchanan gave an account of a Method of Staining the Blood Elements, designed to show a difference in the staining characteristics of the red cells of pernicious anæmia. He also gave an account of the centrosome and attraction sphere of cells.

LARYNGOLOGICAL SOCIETY OF LONDON.—A meeting of this society was held on Feb. 3rd, Mr. Charters J. Symonds, the President, being in the chair.—Mr. C. A. Parker showed a case of Tuberculosis of the Larynx in a woman, aged 31 years. The disease commenced during her fourth pregnancy, since which she had been pregnant five times. On three occasions the child was born alive and on two occasions she had miscarriages.—Mr. H. Clayton Fox showed, for Dr. Frederick Spicer, a case of Diffuse Papilloma

of the Vocal Cords; and Dr. Edward Law showed a man, aged 69 years, from whom a Laryngeal Growth was removed 21 years ago from the right vocal cord by the late Dr. Whistler. Views as to the present condition were invited. Some members were of opinion that the case was malignant but the general feeling was that this was not so.—Mr. P. R. W. de Santi showed two cases, the first being that of a woman, aged 39 years, exhibited at the last meeting, with a laryngeal swelling which was thought to be tuberculous but a microscopical slide now showed that it was undoubtedly squamous-celled carcinoma. The second case was that of a man, aged 60 years, with a large mass of Malignant Glands in the Neck and Swelling of the Larynx on the same side.—Mr. Stephen Paget showed three cases for diagnosis. The first was a case of Fixation of the Left Vocal Cord; the opinion of the meeting was that this was due to aneurysm. The second case was one of Growth of the Right Ventricular Band. The third was one of Growth in the Larynx which was generally regarded as papillomatous though some members inclined to the view that it was malignant.—Mr. F. J. Steward showed a case of Recurrent Ulceration of both Tonsils associated with Lymphadenoma in a woman, aged 64 years.—Dr. F. W. Bennett showed a specimen and photographs of a Malignant Growth of the Larynx and a case of Nasal Ulceration of the Septum for diagnosis. The latter was considered to be a case of ethmoiditis.—Dr. Herbert Tilley showed a case of Primary Sore on the Tip of the Tongue in a man, aged 40 years. There was slight enlargement of the glands but no rash. Some doubt was expressed whether it was not a simple granuloma resulting from the irritation of the caustics which the patient had repeatedly applied.—Dr. G. C. Cathcart exhibited two cases, the first being that of a patient shown at a previous meeting, with Pachydermia Laryngis (?) Tuberculous; and the second being a case of Combined Functional and Organic Paresis of the Larynx in a singer, aged 34 years.

DERMATOLOGICAL SOCIETY OF LONDON.—A meeting of this society was held on Feb. 8th, Dr. J. J. Pringle being in the chair.—Dr. T. Colcott Fox showed (1) a man, aged 50 years, who had lived in India and who, six months after his return to England, had developed a generalised pruriginous eruption all over the body and limbs. There were to be seen small infiltrated obtuse papules situated rather deeply in the skin, showing no grouping and not developing into vesicles. The case resembled both the prurigo of Hebra and the eruption described under the name of pseudo-leukæmic prurigo, but there were no enlarged glands or any signs of lymphadenoma. (2) A man who was suffering from an attack of Ordinary Eczema of the Lumbar Region but in whom were found accidentally, on stripping the back to view the eczema, many large nodes situated deeply in the hypoderm over the last two ribs on the left side. The question was, Were these gummata or some kind of true tumour formation? They had been in existence for six years. The majority of members thought that they were probably gummata.—Dr. Pringle showed a man, aged 64 years, with Extensive Symmetrical Sclerodermia of seven years' duration. The patches extended over almost the whole of the legs below the knee, on the thighs, over the area roughly corresponding to the second lumbar segments according to Head, and from the styloid processes of the ulnæ up to the tips of the olecrana, thus corresponding to the first dorsal nerve areas.—Dr. J. H. Stowers showed a case of Mixed Sclerodermia. The disease started eight years ago with the appearance of a patch on the left breast and subsequently two more patches appeared in the neighbourhood of this. Two years ago the left arm began to waste and when shown there was extensive sclerodermia with rigidity and partial immobility of the elbow-joint from the contraction of the skin. Most of the patches showed the characteristic ivory-white appearance but in some situations there was marked telangiectasis.—Dr. F. Parkes Weber showed a well marked case of Kaposi's Idiopathic Pigmented Sarcoma in an elderly man, with sections from one of the growths. The usual marked œdema and almost purple colouration of the limb were present.

SOUTH-WEST LONDON MEDICAL SOCIETY.—A meeting of this society was held at the Bolingbroke Hospital, Wandsworth Common, on Feb. 8th, Mr. E. F. White, the President, being in the chair.—Mr. G. H. Makins gave an address entitled "Some Remarks on the Indications for, and the Results of, the Operation of Gastrojejunostomy." He observed that as to the choice of operation the two main methods open to the surgeon were the anterior and the posterior operation, the object of either being the provision of an efficient anastomosis with the small intestine to short-circuit the pylorus, the most important technical points being the insurance of an opening of sufficient size and that this should be at the most dependent part of the stomach. What is the most dependent part of the greater curvature? By the aid of diagrams this was shown to be beneath the left rectus muscle. The stages of the operation were then reviewed. In preparing the patient it was desirable to wash out the stomach for two or three days prior to operation but not on the day of operation. The skin should be shaven dry, ether soap rubbed in, and the skin scrubbed lightly with a brush, the soap removed with clean swabs, and ether or turpentine applied. An incision from three and a half inches to four inches long was made through the left rectus muscle. A small incision was best as a slight amount of plugging only was then necessary. The stomach was drawn out and a search was then made for the piece of jejunum wanted. The two pieces of bowel were then clamped with Doyen's clamps. A simple running suture carried obliquely across was the best as it equalised the tension between the sutures and controlled hæmorrhage. A fine silk suture sufficed. The clamps and plugs having been removed the abdominal wound was closed and collodion applied, and it was then covered with gauze soaked in a mixture of gelatin and salicylic acid to which some formalin (one drachm to an ounce) had been added. Two days' rectal feeding was enough. The dressing was comparatively *nil*. Regurgitant vomiting was the chief after-trouble. The possible explanations were: (1) the intestine had not been attached to the lowest part of the stomach; (2) the mucous membrane was redundant and a valve was formed which prevented the flow from the stomach to the intestine; and (3) the opening was too small. Some regurgitation always took place and usually did no harm. The indications for the operation were: 1. Pyloric obstruction. In pyloric obstruction due to carcinoma it could be done in any case if sufficient room was left by the disease. The condition of the patient was sometimes a bar, and this was where the mortality of the operation came in. The relief was temporary but this objection was much less than the similar objection which might be raised against colotomy. Where there was ulceration of the growth the relief from pain was very great. 2. Cicatricial contraction. Here the operation was sometimes absolutely simple and successful but in other cases it was a troublesome one. 3. Congenital hypertrophic stenosis. In these cases it was not a good operation, the intestine being too thin and tenuous, and the results had been bad. 4. As an operation of expediency. The operation had been widely recommended and practised for gastric dilatation of unknown causation, for simple gastric ulcer, and for gastric and duodenal hæmorrhage. It has been recommended on the grounds of securing physiological rest. By the freer drainage of the gastric contents it was said to relieve pyloric spasm. Again, the ulcerated surface was less irritated; hence there were relief from pain and less chance of hæmorrhage. Cases were quoted to show that some fallacy might exist in the results seen after these operations mainly due to errors of diagnosis and perhaps less commonly to the failure of the operation to perform what was expected of it.

OTOLOGICAL SOCIETY OF THE UNITED KINGDOM.—A meeting of this society was held on Feb. 6th, Dr. Thomas Barr, the President, being in the chair.—The President delivered an address in which he spoke at some length on the institution of research work and the formation of a permanent museum in connexion with the society. He said that since the time of Toynbee the pathological anatomy of the ear had not received adequate attention in this country. The pathologist habitually ignored it in the post-mortem room and yet there was probably no part of the body in which a thorough examination was more important in the interest of progress. The thorough examination of the temporal bone and organ of hearing, however, required more time and technical experience than fully occupied otologists could usually command. Moreover, the operative work which they had to perform rendered it perhaps undesirable that they should engage in post-mortem investigations. He therefore suggested that it might be possible to make arrangements by which temporal bones sent by any member of the society might be examined anatomically and pathologically by young

men specially interested in otology and possessed of the requisite knowledge for conducting such researches. A permanent museum would be a great addition to the resources of the society, for otology lent itself to the production of anatomical and pathological specimens.—A discussion then took place on Mr. Charles J. Heath's address, entitled "The Restoration of Hearing after Removal of the Drum and Ossicles by a Modification of the Radical Mastoid Operation for Suppurative Ear Disease." This address was delivered before the society on Dec. 5th, 1904, and was published in THE LANCET of Dec. 24th, p. 1767. Several speakers said that the operation described was practically the one already known as Stacke's, or the Schwartze-Stacke, operation.—Mr. Heath, in his reply, said that he had referred to his operation as a modification of Stacke's operation. The only statistics which he could quote were as follows: average duration of treatment before operation, 13 months; average duration of the disease, 15 years; proportion of cases with improved hearing, 84 per cent.—Dr. William Milligan read notes of two cases of Labyrinthine Suppuration recently operated on, with special reference to the path of infection. The patients were males, aged respectively 37 and 46 years. In both of them the duration of the disease was at least 20 years and the result of the treatment was complete recovery.—Dr. Herbert Tilley read notes of a case of Acute Labyrinthine Suppuration in a male patient, the subject of chronic otorrhœa. The radical mastoid operation was performed and recovery followed.—Mr. L. Lawrence showed a patient suffering from Chronic Non-suppurative Middle-ear Disease, in whom a mere touching of either tympanic membrane produced marked and rapidly extending hyperæmia. The condition might be called "urticaria of the drum."—Mr. Arthur H. Cheatle exhibited 250 Temporal Bones obtained from patients at all ages; these bones were sectioned vertically through the antrum and mastoid process.—Mr. Hunter F. Tod read notes of a case of Hernia Cerebri et Cerebelli the result of acute encephalitis. The patient was a boy, aged ten years, in whom acute middle-ear symptoms developed in June, 1904. Schwartze's operation was performed and seven days later the hernia was discovered. Gradual recovery followed and hearing was now normal on the affected side.—Other patients were shown by Mr. Ernest B. Waggett, Mr. Richard Lake, and Dr. H. M. Macnaughton-Jones.

HUNTERIAN SOCIETY.—A clinical meeting of this society was held on Feb. 8th, Dr. F. J. Smith being in the chair.—Dr. Purves Stewart showed a case of Oculomotor Paralysis of the Eye of a woman suffering from tertiary syphilis. She was rapidly recovering under treatment with iodides and mercury but still exhibited divergent strabismus and weakness in the action of the superior, inferior, and internal recti muscles, a dilated pupil, and weakness of accommodation. Ptosis was also present with corrugation of the forehead on the same side, a sign which was not present in hysterical ptosis. The gummatous process probably affected the nerve at the point at which it pierced the dura mater.—Dr. Stewart also showed a case of Cervical Sympathetic Paralysis due to division of the second and third dorsal roots on the right side by a Mauser bullet in the Boer war. The pupil was contracted on the same side and did not dilate on shading from light or pinching the lobule of the ear. The eye was sunken into the orbit owing to paralysis of Müller's muscle. There was ptosis to a slight degree on the same side for the plain muscle fibres in the upper lid were paralysed. The area of sweat fibres supplied by the cervical sympathetic had been marked out on this man and had been found to be the exact half of the head and neck, the front of the chest as low as the nipple and the back as far down as the lower angle of the scapula and the whole of the upper limb. The man was induced to sweat. Then charcoal was puffed over him and adhered to the sweating area. The area of paralysis was dry and the charcoal did not adhere. The patient was then photographed and these photographs were shown to the meeting. Photographs exhibiting spasm of the sympathetic from a case of Graves's disease were also exhibited for contrast.—Dr. Smith, Dr. W. Langdon Brown, Dr. R. Hingston Fox, and Mr. Harold L. Barnard took part in the discussion of the cases.

ROYAL MEDICAL SOCIETY, EDINBURGH.—A meeting of this society was held on Feb. 10th.—Dr. F. W. N. Haultain read a paper on Fibroid of the Uterus. He said that he divided fibroids into two classes—those which gave rise to symptoms and those which did not—and he stated that the condition was more common than one suspected, for probably one in every five women was affected, though the proportion of cases in which the growth became malignant was infinitesimal. In the course of his remarks he considered the question of operative interference in cases where there were inconvenient symptoms and he stated that it was his opinion that the operation should be performed in all such cases when the patient was young and that the approach of the menopause was a contra-indication. He continued by discussing the kind of operation to be performed and stated that he was in favour of suprapubic hysterectomy. Dr. Haultain concluded by giving an account of the clinical and pathological aspects of some of his own cases. During the course of his paper he exhibited some interesting specimens.—Dr. A. C. Geddes moved, and Mr. J. D. Wells seconded, a vote of thanks.—Dr. H. N. Fletcher read a dissertation by Dr. Matthews on Tuberculous Peritonitis.

BRISTOL MEDICO-CHIRURGICAL SOCIETY.—A meeting of this society was held on Feb. 8th, Dr. Reginald Eager being in the chair.—Mr. H. F. Mole showed the following patients and read notes of their cases: (1) an infant operated on for Spina Bifida at 14 days old; (2) a case of Ruptured Intestine; (3) a case of Colectomy, &c., for Carcinoma of the Colon; and (4) a case of Excision of the Wrist for Tuberculous Disease.—Dr. J. J. S. Lucas showed (1) a case of Recovery from Tuberculous Meningitis; (2) a case of Exophthalmic Goitre in a man with Glycosuria; and (3) a speciman of Congenital Malformation of the Intestine.—Dr. J. M. Fortescue-Brickdale showed a specimen of Congenital Dilatation of the Ureter and Cystic Kidneys in a child.—Dr. Theodore Fisher showed a specimen of Chloroma of the Dura Mater, and Dr. J. E. Shaw read the clinical notes of the case.—The cases and specimens were discussed by a number of the members present.

PATHOLOGICAL SOCIETY OF MANCHESTER.—A meeting of this society was held on Feb. 8th, Dr. T. Harris being in the chair.—Mr. A. J. Rodocanachi showed a Vesical Calculus which he had removed by vaginal lithotomy. It had been deposited upon a vulcanite button with which someone had plugged a vesico-vaginal fistula following hysterectomy and had been forming for over two years.—Dr. Nathan Raw showed specimens of Lymphosarcoma of the Lungs. Dr. W. J. S. Bythell and Dr. D. Orr gave a lantern demonstration of Colour Photography as applied to Pathological Histology.—Other specimens were shown as card specimens.

WEST KENT MEDICO-CHIRURGICAL SOCIETY.—A meeting of this society was held at the Royal Kent Dispensary, Greenwich-road, S.E., on Feb. 3rd, Mr. G. Chisholm Williams, the President, occupying the chair.—Mr. Charles H. Evans of West Norwood and Dr. A. E. Jerman of Erith were duly elected members of the society.—Mr. E. G. Annis, medical officer of the borough of Greenwich, read a paper on Immunity against Disease.

Reviews and Notices of Books.

A Text-book of Clinical Diagnosis by Laboratory Methods. By L. NAPOLEON BOSTON, Director of the Clinical Laboratories, Medico-Chirurgical College, Philadelphia. With 320 illustrations, many in colours. London and Philadelphia: W. B. Saunders and Co. 1905. Pp. 549. Price 18s. net.

THE title on the back of this work hardly conveys an exact idea of its contents, although its sub-title might. It deals chiefly with microscopical and chemical methods applied to the study of disease and there is nothing about auscultation, percussion, or other physical methods of this kind. To some readers the introductory chapter on the Use of the Microscope might seem almost unnecessary but of this we need not complain, for some practitioners to whom this work will prove of great value may find the hints regarding the method of using, cleaning, and observing with immersion lenses very useful.

About 150 pages are devoted to the blood under the following heads: tests for its recognition, estimation

of its volume, the histology of fresh blood, its bacteriology and the study of fixed and stained films, special pathology, and the parasitic diseases affecting it. The more recent methods for examining and staining blood are fully and carefully described and the subject is illustrated by many original drawings, all of them of great beauty and accuracy. Anyone by following the excellent descriptions could soon make himself master of the subject. Amongst the coloured plates are those on the blood corpuscles of various animals, erythrocytes in various diseases, and the blood in pernicious anæmia, chlorosis, and myelogenic, lymphatic, and spleno-medullary leukæmia. Cryoscopy is also introduced. This is a method which may come to play an important part in the diagnosis and the prognosis of some renal diseases. Every method of clinical value for the study of the blood is fully given and with a wealth of illustration not common in some clinical manuals. The importance of serum diagnosis is emphasised and its methods are fully set forth. The protozoan parasites which invade the blood of the lower animals are described together with the malarial parasite, of which a particularly full account is given, illustrated by many figures in the text and also by coloured plates. The various changes of the blood—in its corpuscles and fluid part—in acute infectious and other diseases are all carefully described and a comprehensive account is given of the parasitic diseases affecting the blood.

To the urine 240 pages are given and here again there is the same wealth of illustration by means of figures and coloured plates. Some of the woodcuts might be omitted—e.g., that of a nest of beakers—and the same remark applies in some other chapters. This subject is set forth under the following heads: physical, chemical, and microscopical. In addition to a full account of the method used the significance of the facts observed in relation to disease is stated. The influence of some drugs on the excretion of the urinary constituents is given. A rather larger chapter than usual is devoted to the sulphates—constituents of the urine which clinicians sometimes are likely to neglect. Seeing that the sulphur excreted has an intimate relation to proteid metabolism it deserves careful consideration and estimation. The loosely combined sulphur in the urine is a factor many chemists regard as a pre-eminent feature which distinguishes Bence-Jones albumose from the digestive albumoses as well as from histon and globin. The author gives his own method for its estimation (p. 188). The xanthin and purin bodies are now beginning to attract more attention and are dealt with accordingly. In describing the detection and the estimation of proteids the author sets forth his own method for applying the old nitric acid test (p. 207). In this connexion, he says, he has "found but two reagents that are capable of withstanding the tests necessary to render them worthy of special clinical mention—viz., concentrated nitric acid and the nitro-magnesium mixture of (Sir William) Roberts, which is composed of nitric acid two parts and saturated magnesium sulphate solution ten parts." There is a surprisingly realistic drawing on Plate 14 showing Fehling's test, the manner of conducting it, and the precipitate of the red cuprous oxide, besides which tests for glucose, lactose, and the tests for the pentoses are given. Oliver's peptone test for bile salts (p. 240) is cited as one of the most delicate and trustworthy for the detection of bile acids in the urine. The value and the significance of the diazo reaction are fully discussed.

The subject of gastric contents occupies about 50 pages. As to the detection of free hydrochloric acid dimethylamido-azobenzol is placed first as the most sensitive reagent and is followed by phloroglucin-vanillin, while Töpfer's method for its estimation is given as "sufficiently accurate for practical laboratory studies." A full account is given of the fæces, more particularly of their fauna and flora, both of which are extensive. The organisms found are well illustrated by many figures. The sputum, buccal and nasal secretions, discharges from the ear, the eye, and the genital organs, the synovial and cerebro-spinal fluid, and milk are successively dealt with and with equal fulness and lucidity. An unusual amount of space and fulness of treatment are given to the subject of transudates and exudates and to the parasitic diseases of the skin.

This work is compact, trustworthy, comprehensive, and well illustrated, and we most cordially commend it as a serviceable and practical treatise on the subjects with which it deals. Nothing has been spared in the way of illustration which could help to make it both useful and attractive.

Surgical Diseases of the Abdomen with Special Reference to Diagnosis. By RICHARD DOUGLAS, M.D., formerly Professor of Gynæcology and Abdominal Surgery, Medical Department, Vanderbilt University, &c. Illustrated with 20 full-page plates. London: Rebman, Limited. 1903. Pp. 883. Price 30*s.* net.

THE importance of abdominal surgery at the present day can hardly be overestimated. A large proportion of the major operations performed now deal with this cavity and its contents and some of the greatest recent advances in surgical knowledge and treatment have reference to the viscera of the abdomen. The volume under review deals but briefly with operative technique but is devoted chiefly to the question of diagnosis, which is of paramount importance, for the treatment cannot be determined satisfactorily until the diagnosis is made. There is no small risk nowadays of the diagnostic art losing much of its value from the tendency which exists to postpone the diagnosis until an exploratory laparotomy has been performed. This course is no doubt sometimes necessary, for the diagnostic signs may be too few and too obscure to allow a diagnosis to be made, but the too ready recourse to abdominal section cannot fail to discredit operation in the eyes of the lay public who hardly recognise the difference between an operation for diagnostic purposes and one for treatment. Dr. Douglas's work is therefore especially valuable in that it devotes a large proportion of its space to the question of diagnosis. We have perused the book with much pleasure, for it is representative of modern surgery and though the therapeutic sections are brief, yet we frequently find useful and valuable notes in them. We may quote the recommendation that when irrigation of the abdominal cavity has been employed in peritonitis it is well to leave the abdomen full of saline solution, for the author tells us that it relieves shock, allays thirst, and tends to prevent post-operative adhesions. Each chapter is followed by a list of the recent works and articles on the subject and this should prove of great assistance to the reader. The author is evidently well acquainted with current literature and his views seem to be sound. The work can be recommended as containing an accurate account of the surgical diseases of the abdomen, especially from the point of view of diagnosis.

Diseases of the Ear, for Practitioners and Students of Medicine. By JAMES KERR LOVE, M.D. Glasg., Aural Surgeon, Glasgow Royal Infirmary; Lecturer in Aural Surgery, St. Mungo's College, Glasgow; Aurist to the Glasgow Institution for the Education of the Deaf and Dumb. Bristol: John Wright and Co.; London: Simpkin, Marshall, Hamilton, Kent, and Co., Limited. 1904. Pp. 339, with 54 photographs, two coloured plates, and many illustrations. Price 25*s.*

Dr. Love tells us in the preface to this large and elegant book that his chief object is to spread a sense of the responsibilities which the modern treatment of suppurative diseases of the ear has thrown on the general practitioner and on the aural surgeon. He has therefore devoted a large proportion of his work to this subject.

He gives a very careful review of the anatomy of the ear, which is written in an extremely easy and almost conversational manner, a matter of moment considering the importance, and at the same time the usually uninteresting character, of that knowledge of anatomy so necessary to safe procedure in all operations about the ear. In fact, Dr. Love emphasises, though he does not actually quote, the advice given by Billroth, "Anatomy, gentlemen, and again anatomy." In discussing the physiology of hearing and sound in its relation to hearing Dr. Love takes his readers so deeply into the theory of music as to be beyond the comprehension of the average practitioner or student.

A chapter is devoted to Diagnosis and Methods of Examination and repays a close and careful study; if thoroughly mastered, it will enable the reader to recognise to a very large extent the various diseases of the ear and their classification. The hints given with regard to the application of the various tests are extremely practical and the description of the tests shows knowledge of the subject. Another chapter deals with General Prognosis and Treatment. Prognosis is considered under two heads—those of hearing and danger to life. General treatment is divided into the prevention of disease, the management of deafness not associated with suppuration, and the management of suppurative disease. Under the management of disease not associated with discharge from the ear the author most truly remarks that the indications are for the early removal of the causes and the vigorous treatment of the deafness at the earliest possible stage, a piece of advice which it would be well, were it possible, to instil into the public mind. A description of Diseases of the External Ear and of those of the Nose and Naso-pharynx in their Relationship to the Ear, in which most of the minor intranasal operations necessary in indirect treatment of aural affections are briefly explained, is followed by descriptions of Diseases of the Middle Ear, which are again divided into Suppurative and Non-suppurative, Acute or Chronic. There is nothing very noticeable in the descriptions except the importance attached to the phenomenon known as paracusis Willisii as pointing to the disease being most probably aural catarrh, a statement which is elaborated later. Notice of diseases of the middle ear has been unnecessarily abbreviated and far too little attention is paid to affections forming so large a proportion of those diseases which the practitioner is called upon to treat and the proper treatment of which is of such essential importance to the patient, though the various operations that have been suggested for the improvement of chronic non-suppurative disease of the middle ear are carefully and ably dealt with. The author is in agreement with most of his compatriots when he says that such operations do not offer an encouraging field for the activity of the surgeon. A chapter on Deaf Mutism contains a very practical account of the methods of diagnosing and treating this condition, this being a subject in which Dr. Love has established himself as an authority. The latter part of the book consists of a series of 54 stereograms which are viewed through a small stereoscope supplied by the publishers, a method of teaching anatomy which is only to be excelled by handling actual specimens.

We congratulate Dr. Love on the ability with which he has carried out his task and we are of opinion that the book will prove of value as a work of reference for practitioners and students. The type, by the way, has been carelessly set.

LIBRARY TABLE.

Epizootic Lymphangitis. By Captain W. A. PALLIN, F.R.C.V.S. With 17 plates. London: Published by Williams and Norgate for the University Press of Liverpool. 1904. Pp. 53-xxi. Price 2*s.* 6*d.*—This little work of 53 pages is from the pen of a member of the Army Veterinary Department who had exceptional opportunity for studying the disease when on service in China, South Africa, India, Japan, and latterly in Ireland. Captain Pallin enters fully into the early history and the geographical distribution of the disease. He describes fully, with illustrations, the causal organism (a cryptococcus) together with the best and most recently discovered methods of staining and cultivation. For the benefit of practitioners chapters are devoted respectively to the incubative period, the symptoms, post-mortem appearances, differential diagnosis between this disease and glanders, prophylactic measures, and the prospects of treatment both internal and external. The predisposing causes and the general methods of infection are fully described. The illustrations are so clearly reproduced that, in themselves, they enable the reader to see at a glance the specific lesions. The last 20 pages are devoted, in the form of an appendix, to the recent regulations which have been put into force in Great Britain by order of the Board of Agriculture and Fisheries. The book reflects credit upon the author and the publishers.

Tuson's Veterinary Pharmacopœia. Sixth edition, revised and edited by J. BAYNE, F.I.C., F.C.S. London: J. and A. Churchill. 1904. Pp. 376. Price 7*s.* 6*d.*—A book which has reached its sixth edition scarcely needs any recommendation, and in this edition, as in the previous ones, the original arrangement has been adhered to. Some new preparations in general use by veterinary practitioners have been added and alterations have been made in accordance with the British Pharmacopœia of 1898. Tuson's Pharmacopœia is mainly a compendium of drugs and preparations in common use by veterinary surgeons, occupying a similiar position in the veterinary world to that held by Martindale's Pharmacopœia in relation to human medicine. The book is well got up and neatly bound and will no doubt be as serviceable as the previous editions have been.

Ship Surgeon's Pocket-book and Medical Officer's Log. By W. E. DAWSON, formerly Admiralty Surgeon and Agent. London: Baillière, Tindall, and Cox. 1905. Pp. 61 and blanks. Price 2*s.* 6*d.* net.—The manuscript of this small vade-mecum has been its author's constant companion in his voyages round the world. It contains valuable hints and a tyro who provides himself with a copy before going on board will avoid some of the difficulties incidental to the commencement of a ship surgeon's career. The surgical notes may be regarded as "refreshers." Useful regulations for medical officers are given as is also a specimen page of a medical officer's log. Blank pages are added for notes of cases. The book might, we think, have been produced at a lower price.

Radium Explained: a Popular Account of the Relations of Radium to the Natural World, to Scientific Thought, and to Human Life. By Dr. W. HAMPSON, M.A. With illustrative diagrams. London: T. C. & E. C. Jack. 1905. Pp. 122. Price 1*s.* net.—This little book is written for the more thoughtful section of the people in order that they may obtain some more systematic and intelligible information about radium than can be gathered from articles in the daily press and from contributions to the monthly magazines. The account is intended to make clear, in the first place, what there is in the processes underlying the nature and the actions of radium to give them such a hold on the consideration of the scientific world and to justify so much general interest and surprise; secondly, to show how the knowledge obtained in connexion with the study of radium has modified scientific views as to the constitution of the natural universe; and thirdly, to set forth impartially the limits of the practical benefit which we get from radium now and the hopes that may be rationally entertained in that direction for the future. The whole book can be understood without more scientific knowledge than forms part of the

common intellectual currency of mankind. The author in his conclusion says that "scientifically our great obligation to radium is on the score that it has so powerfully stimulated energy, perseverance, and ingenuity in various new methods of putting nature to the question, with the result that we have already had a flood of light thrown upon atomic structure and atomic energy. And it is likely that the light will before long reach far enough to enable us to see right up to the boundaries which human knowledge is never likely to pass—the region where all kinds of energy are resolvable into the one simplest and most universal form of motion, all forms of matter into the smallest units admitting of no further analysis, and all natural laws into one simple statement of the constant relation between elementary motion and units of matter." The book should afford a great amount of pleasure to a large circle of readers. It is very readable.

Robert Louis Stevenson: a Record, an Estimate, and a Memorial. By ALEXANDER H. JAPP, LL.D. With hitherto unpublished letters in facsimile. London: T. Werner Laurie. 1905. Pp. 308. Price 6s. net.—This book will no doubt be widely read by the many who love Stevenson's writings and who through them and through the many accounts of his life and doings which have appeared have learned to love the man. One of the best portions of the book is that which tells of Stevenson's relation to his parents—a relationship so eminently human and beautiful. The charming letters written to his friends in England certainly reveal the man to us from many standpoints—reveal him in his strength and in his weakness, reveal his largeness of heart, his delicacy, his sympathy, his fun, his pathos, his boyish frolicsomeness, his fine courage, his love of the sea, his passion for action and adventure despite his ill-health; they tell of his great patience and of his sweet temper. The book has been a labour of love and Dr. Japp has brought Stevenson vividly before us.

Wellcome's Photographic Exposure Record and Diary (Northern Hemisphere), 1905. London, Sydney, and Cape Town: Burroughs, Wellcome, and Co. Pp. 226. Price, red buffing grain, 1s. 6d.; art green canvas, 1s.—This useful pocket encyclopædia for photographers which, when fastened up ready for the pocket, measures approximately five and a half inches by three and a half inches, contains a lot of information in a clear and compact form. There are records and indexes of negative exposures and of positive exposures, a diary for the year and pages for memoranda, copious notes on exposure, development, printing, toning, and fixing, and on copying, enlarging, reducing, and telephotography. A neat and easily understood moveable disc exposure calculator is affixed to the inside of the back cover. By the simple and ingenious arrangement of reversing the usual order of the months and making the table of "light values" for January the last page in the book, facing the exposure calculator, and perforating the pages for each month so that after January is torn off February appears facing the exposure calculator, the trouble of referring to back pages is avoided. A long list of the "speed values" of various makes of dry plates is given for use in conjunction with the exposure calculator. As usual, there are two editions of the book, one for the northern hemisphere and one for the southern. The book cannot fail to be of great interest and use to every photographer who prefers to go about his work in a thoroughly scientific and methodical manner.

Meals Medicinal with "Herbal Simples": Curative Foods from the Cook, in place of Drugs from the Chemist. By W. T. FERNIE, M.D. Durh. Bristol: John Wright and Co.; London: Simpkin, Marshall, Hamilton, Kent, and Co. 1905. Pp. 781. Price 9s.—"The purpose of this handbook is to explain what are the curative constituents of such dishes and table-waters as a doctor can adequately order instead of drugs when prescribing against diseases; these same matters of diet being actually medicinal, though in the pleasant guise of eatables and drinks to suit the palate." The author provides an "armament of weapons" for active service alike in sickness and during convalescence therefrom. The main portions of the author's previous work, "Herbal Simples," are reproduced in the present book, which is intended to instruct both the medical and the lay reader. The author has promoted himself to the advanced office of a physician-chef. The index at the end of the volume is very much more than the usual list of references. In the index under the heading of each of the commoner diseases is given not only a list of dietetic remedies but also copious references to the text of the volume concerning each remedy recommended. The work has been carefully prepared and it is, of course, a truth that health may be maintained by suitable diet, while as an old writer reminds us "a good Coke is half a Physycyon," but the book promises too much.

Proceedings of the National Veterinary Association.—We have just received the report of the above association, a meeting of which was held in August last at Leinster House, in the rooms of the Royal Dublin Society, under the presidentship of Mr. Charles Allen, F.R.C.V.S. The proceedings form a most interesting brochure and contain full accounts of the papers read before the association. These include one by Captain Martin of the Army Veterinary Department on Epizootic Lymphangitis, one by Professor G. H. Wooldridge on Hæmoglobinuria in Cattle, and a third on the Selection and Purchase of Army Horses by Mr. Hunting, F.R.C.V.S. Epizoötic lymphangitis of the horse is particularly interesting just now because it is a contagious disease which has recently come to England as a legacy of the South African war. It has been recognised on the continent and in Africa for some considerable time and is due to a cryptococcus. Its symptoms are very much like those of glanders and it is almost equally intractable. Captain Martin deals very fully with the subject in his paper, his opportunity of seeing the disease in all its stages and the danger of attempting treatment having been exceptional. He is able to record several cures from the use of iodine and iodide of potassium internally, varied with biniodide of mercury, whilst the local lesions were treated by the actual cautery; but the patients were a very long time before they recovered and during that period they were a great source of danger to other horses. The discussion which followed was contributed to by members of the Army Veterinary Department and by civilian practitioners and a lengthy report is given. It is worth while to note that the disease is now scheduled under the Contagious Diseases of Animals Act by the Boards of Agriculture of England and Ireland, so that it is to be hoped that epizoötic lymphangitis will never gain a permanent footing in the British Isles. The paper on Hæmoglobinuria in Cattle by Professor Wooldridge is profusely illustrated with reproductions of photographs and lantern slides, and shows that the author has paid a great deal of attention to the subject. It is now recognised that this disease is caused by a parasite belonging to the protozoa and known as the piroplasma bovis. These parasites are to be found in the blood of affected cattle; they are pear-shaped or willow leaf-shaped and are readily stained in the following way (Mettam): "After drying and fixing in absolute alcohol, or alcohol and ether, stain for ten minutes in 1:1000 of watery solution of eosin and then in thionin two parts, methylene blue one part, polychrome blue one part. It may be necessary to decolourise carefully with alcohol or the order of staining may be reversed so that the eosin may discharge some of the blue." Professor Wooldridge demonstrates clearly that blood corpuscles contain various

forms of piroplasma bovis, showing films prepared from affected animals in various parts of Ireland, and he also showed actual specimens of the varieties of ticks which are the intermediate hosts and the source of contagion from one beast to another. Medicinal and other curative treatments are entered into fully both by the author and by those who joined in the discussion. In the paper on the Selection and Purchase of Army Horses Mr. Hunting deals with what he considers to be the proper ages of horses at time of purchase in peace and in time of war. He discusses the questions of Government assistance to the breeder by contribution and subsidy, and he concludes his paper by a few words on the transport of animals across the sea. In the discussion which followed the paper the methods which were adopted during the recent war came in for a good deal of criticism, it being universally agreed that the way in which horseflesh was purchased and wasted cost the taxpayers of the country many hundreds of thousands of pounds unnecessarily.

JOURNALS AND MAGAZINES.

Ophthalmology. Vol. I., No. 2. January, 1905. Published by H. V. WÜRDEMANN, M.D., and NELSON MILES BLACK, M.D., of Milwaukee, aided by a large editorial staff. Publishing office: 105, Grand Avenue, Milwaukee, Wis., U.S.A. A quarterly journal, price per number, 6*s*.—The original articles in this number of *Ophthalmology* are six. 1. On Congenital Word-blindness, by William Evans Bruner, M.D. 2. Binocular Fixation and the Hypothesis of the Dominant Eye, by Percy H. Friedenberg, M.D. 3. Cases of Retinal Separation, by Allen Greenwood, M.D. 4. Report of Comparative Tests of Coloured Glass used in Railway Signalling, by Nelson Miles Black, M.D. 5. Improved Series of Wools for the Detection of Subnormat Colour Perception, "Colour Blindness," by Charles A. Oliver, M.D. 6. The Medico-legal Relations of Ocular Injuries, Pensions, and Insurance Rates, and a Reference to a Scientific Plan for estimating the Loss of Earning Ability, by H. V. Würdemann, M.D. In addition there are numerous abstracts from current ophthalmic literature and reviews of books.

The Ophthalmoscope. Editors: SYDNEY STEPHENSON (London) and CHARLES OLIVER (Philadelphia); sub-editor, C. DEVEREUX MARSHALL (London). London: George Pulman. Vol. III., No. 2. February, 1905. Price 1*s*.—This number contains three original articles on the Use of the Magnet in Ophthalmic Surgery. The articles are written by Professor J. Hirschberg, Professor O. Haab, and Mr. S. Snell and are all of considerable interest. They are briefly noticed in another column. A section of the review is devoted to current ophthalmological literature and another to reviews of recent works.

Looking Back.

FROM

THE LANCET, *SATURDAY*, Feb. 17, 1827.

A NEW ELECTRICAL DISCOVERY BY MR. EARLE.

We cannot sufficiently express our satisfaction at being the organ of exclusive communication of a novel and brilliant mechanical discovery of Mr. Earle; our gratification is not the less unalloyed by an anticipation of the extreme chagrin and mortification *Roderick* of the Yellow will experience on a perusal of the following "doings" of his staunch contributor. The case has been extracted from our note book earlier than usual, from the idea, that as spring is rapidly approaching, and all the *world about to physic*, it is highly necessary to know that a morning walk to Mr. Beaume the electrician, is now discovered to be a very genteel and speedy mode of gaining that end, and at the same time of keeping the stomach and mucous membranes intact from their vulgar noisy griping acquaintances, senna and salts. In anticipation of the future fame and gratitude attached to Mr. Beaume's galvanic efforts, we may suggest de Vie as not an inappropriate addition to his already respected name. Beaume de Vie, alias Compound Decoction of Aloes. Such appendage would proclaim at once his calling, and the world's gratitude.

Mr. Earle has had under his care, for a considerable time, a child affected with amaurosis. Its bowels have been constipated; their secretions of a very offensive character; and the biliary secretions, as might be expected, of an unhealthy appearance. The disease of the eyes has been regarded as sympathetic, and the grand sourse of mischief referred to the hepatic organs. Accordingly, mercury has been the grand anchor of hope; calomel, with its irritating step-sister, scammony, has been prescribed without any regard to frequency or quantity. Mr. Earle, at each successive visit, has expressed surprise at *finding no amendment in the biliary secretions*, after the employment of such active medicines. The sovereign remedy was ordered to be followed up with greater vigour, until a healthy action could be induced. But the child's liver was incorrigible, and not to be bullied even by such powerful means. Despairing of success from their further use, the idea of electricity flashed upon his recollection; and forthwith, the liver was electrified. It has been so again and again, but without the wished-for change. If Mr. Earle had himself possessed a little more of the "electrical devil," he would soon have discovered that the continuance of the hepatic derangement was more attributable to the negligence of the dresser, than to the obstinacy of the organ in question. The medicines prescribed, from the commencement were neglected being written for by the dresser, and the child TOOK ABSOLUTELY NOTHING. If Mr. Earle had electrified the *brain of his dresser*, he would have exhibited himself more favourably as a shrewd and attentive hospital surgeon.

NOTICES TO CORRESPONDENTS.

The complaints of a "FRIEND" respecting occasional errors in orthography, are not in some respects devoid of foundation. If he were acquainted with the nature of the evil to be overcome, his excellent judgment would furnish many excuses for that which now appears to be the effect of negligence. As to the *cover*, we take no part in its management, and never see it until the Number is published—this department rests entirely with the Printer.

JEMMY COPLAND says that we cannot *decline* a noun; at all events we have *declined his articles*.

New Inventions.

A NEW FORM OF THIMBLE.

A NOVELTY lately introduced under the name of "Turner's open thimble" seems to present some useful features. It differs from the ordinary form of thimble in having a portion (rather less than one-half) of the side cut away, as shown in Fig. 1, so that even prolonged use of the thimble is not

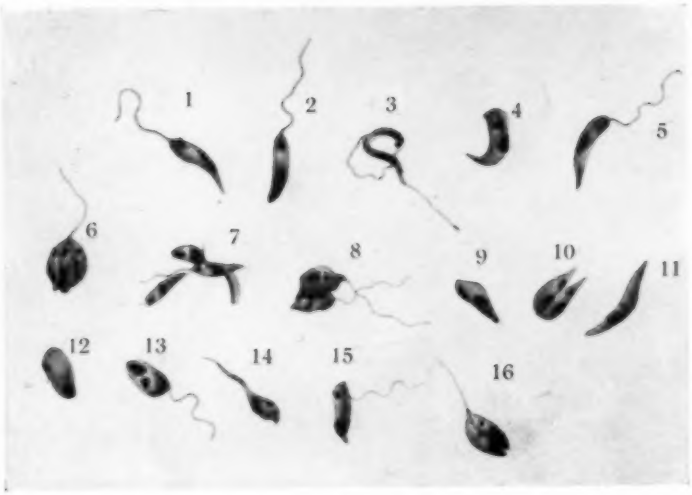
FIG. 1.

FIG. 2.

attended with any compression of the finger-tip and nail. When on the finger the thimble is turned to some extent sideways in such a manner that the outer edge of the nail—i.e., the edge furthest from the thumb—is visible in the centre of the open part. The usual form of the open thimble is as shown in Fig. 1, but it is also made with the top cut off, as shown in Fig. 2. The makers (supplying wholesale firms only) are Messrs. W. Turner and Co., 3, Batavia-buildings, Hackins Hey, Liverpool.

PLATE I.

PLATE II.



TO ILLUSTRATE DR. CHATTERJEE'S AND CAPTAIN ROGERS'S PAPER ON CULTIVATION OF TRYPANOSOMA OUT OF THE LEISHMAN-DONOVAN BODY.

THE LANCET.

LONDON: SATURDAY, FEBRUARY 18, 1905.

The Hunterian Oration.

THE name of JOHN HUNTER can never be forgotten. His services to surgery were so great that we need no Hunterian Oration to remind us of all that he has done and of all that he was. Yet the delivery of such an oration as that of last Tuesday cannot but help us to appreciate more fully, to estimate more highly, the character of the man and the work which he accomplished. We have listened to many Hunterian Orations and we have valued the eloquence of the orators, but we have never been privileged to listen to a Hunterian Oration which contained a more just appreciation of its subject. To devote an hour to mere eulogies of JOHN HUNTER is futile; indeed, no one would have disliked them more than JOHN HUNTER himself. But to occupy the time in pointing out the way in which HUNTER accomplished all he did, to show how he spent his time, his money, and even his life itself in the advancement of knowledge and the attainment of progress, is quite another and a much more appropriate method, and this was the method adopted by the most recent orator, Mr. JOHN TWEEDY, President of the Royal College of Surgeons of England.

To understand JOHN HUNTER'S life three things are necessary. We must first realise the parlous state of the study of anatomy in England in the middle of the eighteenth century. In 1746 WILLIAM HUNTER, JOHN'S elder brother, had commenced the systematic instruction of anatomy, with dissections, for a society of naval surgeons and this was indeed the starting point of the true study of anatomy in this country. The successful practice of medicine and surgery is unattainable without an exact knowledge of the structure of the human body and for this dissection is essential. While the prejudice against dissection was strong, as in the Middle Ages, it was impossible for teachers of anatomy to obtain the material which they needed for dissection: this prejudice had in some degree abated when WILLIAM HUNTER established his school of anatomy and surgery but to a certain extent this unreasonable prejudice against dissection exists even now, for many boards of guardians decline to permit the unclaimed bodies of paupers dying in their infirmaries to be used for anatomical purposes. JOHN HUNTER profited greatly by being introduced early into the progressive school of his brother and this doubtless had much to do in training and fitting him for his future work. But Mr. TWEEDY shows that there was a second cause for JOHN HUNTER'S extensive contributions to surgery. Most of the work of his predecessors was empirical; it was based chiefly on the precedent of previous cases, while of pathology, as affording working theories, there was almost none. HUNTER saw that disease could not be treated satisfactorily without a knowledge of the morbid processes and to obtain that knowledge he strove persistently. He recognised that for the attainment of this knowledge of pathology careful observation was needed of the products of disease and for that reason he set about the formation of a museum. From the first he saw the need of not limiting the study of anatomy and pathology to the human body. He felt that man was so near akin to the lower animals that the study of the vital and the morbid processes of the one must assist in the investigation of the life processes and the diseases of the other; therefore his museum included numerous dissections and examples of the organs of birds, beasts, and fishes. The museum of the Royal College of Surgeons of England, as the present representative of HUNTER'S museum, contains one of the most elaborate collections in the world in illustration of the physiology of animals and plants.

There was a third factor which assisted JOHN HUNTER greatly in the prosecution of his task. All the time during which he was carrying on his extensive and numerous investigations he was in the active practice of his profession. This always suggested to him the application of the facts which he elicited in his researches and thus he possessed a touchstone on which he could try the theories suggested by his facts, which explains the splendidly practical nature of his work. There may have been greater surgeons, better pathologists, and more erudite anatomists than HUNTER but it may safely be said that never in the whole history of medicine has there been a man who devoted himself more thoroughly and more intensely to the advancement of the medical sciences. His influence was great in his own day and from that time to this can be traced in the work of his immediate pupils—ABERNETHY, CLINE, ASTLEY COOPER, and JENNER. At the present time his work is still bearing fruit and his museum, enlarged and extended, is of the greatest value in the advancement of medicine and surgery. So will it be in the future. To few is it given to accomplish so much work while living and to leave behind so vital an effect on the science of succeeding ages; and the reasons why HUNTER will receive the lasting regard of the world are well revealed in Mr. TWEEDY'S eloquent oration, which we publish this week.

The Claims of Sociology.

UNDER the modest title of "Sociological Papers," the recently constituted Sociological Society has just issued what might perhaps be better described as a first volume of "Transactions," containing presumably only a selection from the essays read at its meetings, with reports of the debates, and with written contributions to those debates from absent members to whom advance proofs of the essays had been furnished. At one of the meetings the chair was taken by Professor KARL PEARSON who opened a discussion by declaring that he was not a member of the society and that he was sceptical of its power to do effective work; a declaration which ultimately called forth a reply several pages in length from the secretary, Mr. BRANFORD, but with which, nevertheless, we are disposed to think that most readers of the volume will be likely to agree. It may be admitted that the course of social organisation must be subject to laws which would be

ascertainable if they were rightly sought for; but the efforts hitherto made in this direction have not been conspicuously successful. In 1857 a body called the National Association for the Promotion of Social Science was founded under the auspices of the first Lord BROUGHAM who was said to have been greatly pleased at the "wide and indefinite area" over which its labours were designed to extend. This area was, indeed, so indefinite that the first volume of the Transactions contained a paper by a member of the House of Commons, in which, as a remedy for most of the domestic evils afflicting the lower classes of the labouring population, he gravely proposed that pleasant modulation of the voice should be systematically taught in elementary schools for girls, in order that their future husbands, returning tired from work, should be soothed by the gentle tones of their helpmates and should no longer be subjected to the shrill accents of the scold. For several years the annual meeting of this association was held to be an event of some importance; but its useful work was gradually smothered under a weight of superincumbent trivialities and, after a vain effort to obtain new blood by amalgamation with a society for amendment of the law, it perished from an atrophy mainly dependent upon the unfitness of its nutriment to sustain the vastness of its aims. The new society must to some extent be regarded as its successor and we doubt whether its history is likely to be more fortunate.

The general character of the contributions contained in the volume before us is one of vagueness, arising partly from an absence of sufficiently definite ideas, and partly from an incapacity for expressing them, the latter perhaps sometimes arising from the circumstance that several of the contributors have foreign names, with a consequent probability either that they have written in what was to them a foreign language or that their compositions have been but imperfectly translated. Whatever may be the explanation, we find a general clumsiness of the sentences, a frequent employment of common words in strained or unnatural meanings, and an obscurity of construction which a few well-employed prepositions and conjunctions would have done much to obviate. It is none the less noteworthy that the gentlemen reading papers, and the gentlemen (or ladies) sustaining the discussions, appear to have been profoundly convinced of the importance of their several contributions to the stock of human knowledge; moreover their politeness to one another can only be described as exemplary. It would be difficult to read the reports without some recollection of the historical society described by the poet:—

> "Where, ladling butter from alternate tubs,
> Stubbs butters Freeman, Freeman butters Stubbs."

If proceedings thus conducted are not likely to lead to discoveries of importance, it is at least tolerably certain that they will be sources of harmless pleasure to the great majority of the learned or unlearned persons concerned in them. An important discussion as to which an exception must be made, and which, moreover, was calculated to be of great interest to the medical profession, arose out of the reading of Mr. FRANCIS GALTON'S paper on Eugenics. This paper was so fully referred to when first issued as a "proof under revision," in a leading article in THE LANCET of May 14th, 1904, and has since been so often reproduced in entire or in abbreviated form, that it can hardly be other than familiar to our readers. We need only remind them that its object was to advocate such a system of controlling the reproduction of the human species that the useful classes of the community should contribute more than their proportion to the next generation. The results anticipated by the author are that it might be possible to raise the average quality of our nation to that of its better moiety at the present day. If this could be done, he thinks that "the general tone of domestic, social, and political life would be higher. The race as a whole would be less foolish, less frivolous, less excitable and politically more provident than now. Its demagogues who played to the gallery would play to a more sensible gallery than at present. Men of an order of ability which is now very rare would become more frequent, because the level out of which they rose would itself have risen."

These be brave words and Mr. GALTON'S belief in the possibility of realising what they imply depends upon his corresponding belief in an habitual inheritance by children of the good qualities of their parents. In the very short speech with which he closed the discussion, he said that "much which had been urged against this view might have been appropriately said 40 years ago, before accurate measurement of the statistical effects of heredity had been commenced, but that it was quite obsolete now." As evidence in support of his view he gives, in the volume under consideration, an "Index to the Achievements of near Kinsfolk of some of the Fellows of the Royal Society," the "some" including but eight persons, of whom only one, or at most two, could be described as of the highest eminence. It is scarcely invidious to point out that, even in the Royal Society, there are Fellows and Fellows; but it is more practically important to scrutinise the achievements in question, the great majority of which appear to us to resolve themselves into the capable discharge of duty in positions certainly responsible, but for the attainment of which the persons referred to have enjoyed exceptional facilities dependent upon the social or financial positions of their respective families. We do not regard the existing knowledge of the operation of hereditary influences as being sufficient either to justify the enunciation of general laws or to afford any adequate guidance for the regulation of marriages; and we believe it would be as easy to compile an imposing list of the achievements of persons who are not related to Fellows of the Royal Society as of those who are. What is commonly called an inheritance of genius might often be more correctly expressed as an inheritance of advantages by which a very moderate amount of genius was afforded exceptional opportunities for displaying itself. We expressed last May our doubt whether any science of Eugenics was really in existence, and this doubt has not yet been dispelled. So far as we know, attempts in the indicated direction have not been conspicuously successful in practice. Among the queer so-called "religious" sects now or formerly existing in America, and which were so graphically described by the late Mr. HEPWORTH DIXON, there was at least one in which intended parents were specially selected for pairing by the elders, with a definite view to the production of offspring capable of guiding the affairs of the community to a successful issue. We do not know whether the community

in question still exists as an organised body but we have heard that it never produced a single individual of conspicuous ability.

The Indian Medical Service.

WE have received from time to time communications from officers of the Indian Medical Service, and from some members of the subordinate medical service who are finding employment in civil hospitals all over India, in regard to various points in the existing medical system of the Empire in which they are severally or mutually interested. The present and the future standing of both services and the relationship of the officers one to another are now much under discussion, and the aspirations entertained by many of the more able and ambitious members of the subordinate medical department will certainly serve to keep these topics from neglect. Not so long ago the difficulties were only in prospect and could not be said to be of an urgent kind, so that it seemed to us more expedient to leave the whole situation to mature, when in process of time it might present features which could be more opportunely and usefully discussed. This has now happened and comment seems to us to be called for. Great changes have been taking place in matters of Indian administration generally and in the growth, spread, and development of Indian medical education. Proof of this has been manifested in our columns but some of the correspondence upon these and cognate matters which has reached us has been dictated by feelings that are of a personal or a purely controversial nature and therefore lacking in sympathy with the best interests of both the public medical services and the medical requirements of India. And so the points thus raised may, it seems to us, be usefully discussed at the present time, if only that a most difficult matter may be removed from the sphere of personalities to that of general policy.

Commissioned medical officers of the Indian Medical Service, as everybody knows, are employed extensively as professors at the large medical colleges of the Empire and give instruction at the great hospitals—those of Madras, Calcutta, and Bombay for example. This for a long time past has always been the case. The consequence is that there are now in India large and increasing numbers of really good medical men belonging to Eurasian and native classes who have been thoroughly educated up to European standards. A reference to some of the papers set for the degree examinations of Calcutta, Bombay, and Madras will remove any doubt that may exist as to the rigour of the qualifying tests. These graduates are, as we have said, chiefly employed as subordinates in the civil hospitals all over India and surgical operations of every kind, major as well as minor, are continually being successfully performed by them. Officers of the Indian Medical Service are not alone in their appreciation of the professional value of the work so done, for it is recognised also by Collectors and magistrates of districts and all classes of the native population. The result is that the Government of India is now, or is fast becoming, fairly well supplied with a highly trained body of servants who, so far as professional qualifications are concerned, are capable of undertaking at less expensive rates of pay most of the duties of the commissioned officers of the Indian Medical Service. Indeed, one of our correspondents goes so far as to forecast what, in his opinion, is likely to be in store for the latter service. He expresses his belief that the policy of the rulers of India towards the Indian Medical Service is based upon the principle of utilising the Service mainly in creating for the Government a sufficiently large and efficient number of subordinate medical servants, recruited from the Eurasian and native classes of India. And in support of this view he adds that such a movement while opening an outlet to the present clamour of the intelligent native who desires Government employment for his educated intelligence might at the same time ease the country of a portion of its expensive administration. The Indian Government, he points out, does, moreover, now occasionally employ such medical subordinates to look after the whole medical and sanitary business of large districts containing no inconsiderable European population when there happens to be no commissioned medical officer available for the purpose. Such a letter as that from which we are quoting expresses the spirit of toleration and generosity which all medical men of a right understanding must feel towards their professional brethren. It is not logical—to say nothing stronger—that we should spare no pains to educate the Indian and, at the same time, should refuse him for ever the opportunities of a free exercise of the talents that we have enabled him to cultivate. But the time when a more liberal scheme can be adopted by the Indian Government is delicate to fix—those who know least the difficulties are clearest as to the absolute necessity for immediate reform and most unable to see how valuable it is for future peaceful developments that the change should come so gradually as to appear a merely inevitable process of social evolution. And in considering the question of the increased employment, and the employment in more responsible and highly placed duties, of the native medical graduates we must not ignore the influence which the difference of race introduces into it—not merely those of a physical nature but racial distinctions of character, religion, education, and methods of thought which, however much we may regret their existence, nevertheless tend to keep the European and the native races of India more or less apart. Nor is it the case that the natives of India do not themselves fully recognise these distinctions. It is a topic upon which we would prefer not to enter but so long as human nature is what it is it cannot be ignored. That in respect of trustworthiness of character there are among the members of the subordinate medical service quite a number of unimpeachable servants will be admitted but that the ethical standards of the native and the European are identical cannot be maintained. The native of India, notwithstanding all his confidence in the British character, has profound confidence in himself and is firmly convinced that either he or one of his compatriots is eminently fitted to administer the business of any official post in India. Ask the same native, however, when he is very ill whether he would prefer treatment at the hands of a compatriot or of an officer of the Indian Medical Service and his preference will be immediate and flattering to our race.

Reviewing the whole situation, we believe that it is a misapprehension to consider that the policy of

the Government of India is eventually to displace the European commissioned medical officer in favour of qualified natives or Eurasians. It is certainly not that of the Collector or magistrate, who would strenuously oppose it. Europeans in power in India have naturally enough not the least desire to have either themselves or their families medically treated by either natives or Eurasians instead of by their own countrymen. The education and training of natives of India to be qualified medical men are generally regarded as being among the highest and noblest functions of the Indian Medical Service, so that these men may gradually displace the ignorant "hakedu" and "baid" in ministering to the medical wants of the millions of suffering poor. But it goes without saying that Europeans serving in India will always prefer medical men of their own race. The gradual increase of qualified natives in the towns and the villages has certainly, and very naturally, the effect of diminishing the emoluments from private practice of the officers of the Indian Medical Service, for the former accept much lower fees than the latter and have the advantage of speaking the native languages fluently and of permanency of residence. We consider that it is a legitimate grievance of the qualified natives of India—for it must not be forgotten that it is their country over which we rule—that they are not placed more frequently in medical charge of the smaller districts of India. Whilst the British "raj" lasts, however, in India European medical officers will be required for the larger stations and more important appointments. It would not be for the advance of medical science in India were it otherwise.

Annotations.

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THE King, accompanied by the Queen, opened Parliament in person on Tuesday last. The King's Speech made no allusion to any existing position of affairs or pending legislation of especial medical interest, but its whole quiet confident tone showed that in the opinion of His Majesty's advisers the condition of the country is prosperous and the outlook peaceful. We have so often been told that our trade is going or gone and that we are politically isolated and are living on the edge of war that it can only be good for our nerves, as a nation, to feel that those who ought to know best are not afraid to be both happy and hopeful. Among measures of medical interest we note that legislation is promised dealing with alien immigration, the problem of the unemployed, the compensation of workmen, and the adulteration of butter, but we observe regretfully that nothing is said about legislation with respect to re-vaccination.

THE MACLOGHLIN SCHOLARSHIPS.

Mrs. Macloghlin of Southport has decided to found and to endow some scholarships in memory of her husband, the late Edward Percy Plantagenet Macloghlin, M.R.C.S. Eng., and she has offered to the Royal College of Surgeons of England the trusteeship of the fund. The Council of the College has accepted the trusteeship and will invest and administer the £10,000 which Mrs. Macloghlin will bequeath to it, free of legacy duty. The late Mr. Macloghlin received his medical education at University College, Liverpool, where he gained a number of distinctions, among which may be mentioned the Bligh gold medal in anatomy and physiology and silver medals in medical jurisprudence and toxicology and in pathology. In 1884 he became a Member of the Royal College of Surgeons of England and for several years he practised in Wigan but in consequence of ill health he retired from practice and he died in April, 1904, at Southport. In the early part of his career Mr. Macloghlin was hampered by want of means and it was only by his own exertions that he was able to obtain funds for his education. In later life he did not forget these early difficulties and when success came to him the recollection of his own troubles during his studentship suggested to him the idea of founding a scholarship at the Royal College of Surgeons of England with the object of assisting young medical students in real need of financial help to proceed with their studies. Now that Mr. Macloghlin has died Mrs. Macloghlin offers, in accordance with the wish of her husband, to devote £10,000 to carry out this object. It is thought that when invested an income of about £300 will be available and five scholarships are to be founded, the first to be awarded in the first year succeeding the investment of the fund and another in each of the next four ensuing years, so that afterwards one scholarship will be awarded every year. The scholars are to be young men, between [redacted] ages of 16 and 22 years, studying and seeking to [redacted] themselves as Members of the Royal College of [redacted] England. No student will be allowed to [redacted] scholarship unless he is nominated by the [redacted] will act on the recommendation of certain [redacted] that the student's conduct has been satisfa[redacted] is in need of financial assistance in the [redacted] studies. The candidates so nominated w[redacted] enter for the first professional examinatio[redacted] of Member of the Royal College of Surgeo[redacted] the scholarship is to be awarded to the cand[redacted] best examination. It is intended that chemi[redacted] should form the test subjects of the exam[redacted] endowments for the assistance of medical student[redacted] will be materially increased in importance by [redacted] generous gift of Mrs. Macloghlin and we think that no [redacted] body for the administration of the fund could have been chosen. The yearly amount of each scholarship will be about £60. The total for five years receivable by one student will be £300 and this should prove of very real assistance to many. The struggles which no small number of medical students undergo while working to obtain a qualification are hardly realised even by their more fortunate brethren and not at all by the public. Such assistance as will be afforded by this fund will be of great value.

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OYAL COLLEGE OF SURGEONS OF ENGLAND: HUNTERIAN FESTIVAL.

IN February the anniversary of the birth of John unter is celebrated each year at the Royal College of rgeons of England by the delivery of a Hunterian Oration. is year the oration was delivered by the President of the llege, Mr. John Tweedy. It will be found in full in another lumn and is commented on in a leading article. The ation was followed this year by the Hunterian dinner, hich is held biennially, the President being in the air, supported by the Vice-Presidents, Mr. A. W. Mayo bson and Mr. Henry T. Butlin. About 100 guests ere present, including distinguished representatives of rious professions and callings, as will be seen from the mes: the Duke of Abercorn, the Lord Bishop Dean of Norwich, the Right Hon. James Hon. Mr. Justice Buckley, the Hon. Lawrence, Sir John R. Paget, K.C., more (Mayor of the City of West- cellors of the Universities of Cam- Dean of the Medical Faculty of on, Sir William Ramsay, F.R.S., ral Medical Council, the President Association, Sir Frederick Bridge, mmings, Mus.D., the Headmaster el, Sir Harry H. Johnston, Dr. (surgeon of the National Antarctic iam S. Church (President of the Royal ians of London), Sir William H. Broad- der Brunton, Sir Dyce Duckworth, Pro- fford Allbutt, Sir Frederick Treves, the Director-General of the Medical Department of the Royal Navy, the Director-General of the Army Medical Service, and the Masters of the Merchant Taylors', Salters', Ironmongers', Clothworkers', Skinners', Leathersellers', Apothecaries', and Grocers' Companies. By a curious coincidence the present Master of the last-named Company is Mr. H. Percivall Pott, a descendant of the well-known surgeon, Percivall Pott, who was one of Hunter's teachers and whose name is still well known in connexion with Pott's fracture. The toast of "The King" was proposed by the President who referred to the great interest taken in the medical profession by the King, as shown by the fact that he was an Honorary Fellow of the Royal College of Surgeons of England and also an Honorary Fellow of the Royal College of Physicians of London. He had too shown his interest, perhaps even in a more important way, by his efforts on behalf of the hospitals of London and by his establishment of King Edward's Hospital Fund which was bringing a spirit of intelligent inquiry to bear upon the hospital administration of London and would, it might be hoped, result in the establishment of a rational system of management and expenditure. In proposing the toast of "Queen Alexandra, the Prince and Princess of Wales, and the other Members of the Royal Family," the President remarked that the Queen was a meet helpmate for His Majesty in all good works and that the Prince of Wales showed his interest in hospital affairs by his presidency of King Edward's Hospital Fund. He also alluded to the position held by His Royal Highness as President of the Cancer Research Fund and referred to his recent speech as showing a remarkable grasp of details connected with the problems with which that Fund had to deal. The toast of "The Memory of John Hunter" was then drunk in silence. Mr. Mayo Robson proposed the toast of "The Visitors" and in coupling with it the names of the Duke of Abercorn and Vice-Admiral W. H. Henderson alluded to the good service that was rendered by the committee established under the auspices of the Duke of Abercorn to our sick and wounded officers. The Duke of Abercorn, in reply, said he was glad of the opportunity—the first that he had had—of returning his cordial thanks to those members of the medical profession who voluntarily and generously gave their skill and their knowledge to help the wounded officers whom it was the object of the fund which he had started to benefit. Vice-Admiral Henderson also responded. The toast of "The President and Orator" was proposed by Sir William Ramsay who spoke of the President as "a man of few words but his words contained wisdom." A short reply by the President brought the proceedings to a close. A programme of music was performed during dinner by the band of H.M. Coldstream Guards.

FRENCH COPYRIGHT IN PROFESSIONAL PHOTOGRAPHS.

ON Feb. 10th judgment was delivered in a French law court in the matter of Dr. Doyen *versus* a firm of photographers. The facts of the case were these. In June, 1898, Dr. Doyen conceived the idea of having certain surgical operations "cinematographed" during their performance. Six different operations were photographed jointly by two photographers, M. Clément Maurice and M. Parnaland. The latter, it is alleged, sold prints from these films to the Société des Phonographes et des Cinématographes and the photographs were publicly sold and even exhibited by showmen (*par des forains*) in public places with Dr. Doyen's name in large letters on the posters. The following were the chief terms of the judgment delivered by the court. The court condemned M. Parnaland and the Société des Phonographes et des Cinématographes jointly to pay to Dr. Doyen the sum of 8000 francs as damages on account of the charges. The court ordered in addition that its judgment should be published in 15 journals to be chosen by Dr. Doyen, provided that the price of each insertion should not exceed the sum of 200 francs. The court also ordered the confiscation and the surrender to the plaintiff of the subjects of the action. This decision is of great importance as it lays down definitely the right of men of science to have absolute control over photographs and other graphic documents which may have been taken in their laboratories. The decision is an altogether new one. Our thanks are due to Dr. Doyen for having provided our Paris correspondent with a copy of the judgment from which we have taken the above facts.

HEMIPLEGIA WITH PARALYSIS OF THE THIRD NERVE ON THE OPPOSITE SIDE DUE TO TUMOUR OF THE TEMPORAL LOBE.

HEMIPLEGIA with paralysis of the third nerve on the opposite side usually indicates a lesion of the crus cerebri implicating the motor tract going to the opposite side and the third nerve on the same side. The fact that this rule is not invariable is shown by the following case reported to the Société Médicale des Hôpitaux of Paris at the meeting of Jan. 13th by M. Menetrier and M. Bloch. A woman, aged 40 years, was admitted to hospital with recurrence of cancer of the left breast. The primary growth was removed a year previously. She was in a somnolent condition and answered repeated questions only by the

the Government of India is eventually to displace the European commissioned medical officer in favour of qualified natives or Eurasians. It is certainly not that of the Collector or magistrate, who would strenuously oppose it. Europeans in power in India have naturally enough not the least desire to have either themselves or their families medically treated by either natives or Eurasians instead of by their own countrymen. The education and training of natives of India to be qualified medical men are generally regarded as being among the highest and noblest functions of the Indian Medical Service, so that these men may gradually displace the ignorant "hakedu" and "baid" in ministering to the medical wants of the millions of suffering poor. But it goes without saying that Europeans serving in India will always prefer medical men of their own race. The gradual increase of qualified natives in the towns and the villages has certainly, and very naturally, the effect of diminishing the emoluments from private practice of the officers of the Indian Medical Service, for the former accept much lower fees than the latter and have the advantage of speaking the native languages fluently and of permanency of residence. We consider that it is a legitimate grievance of the qualified natives of India—for it must not be forgotten that it is their country over which we rule—that they are not placed more frequently in medical charge of the smaller districts of India. Whilst the British "raj" lasts, however, in India European medical officers will be required for the larger stations and more important appointments. It would not be for the advance of medical science in India were it otherwise.

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treatment of patients by x ray or other electrical methods but we must confess to some astonishment at finding that either practice is followed by a firm of good standing. We are aware that electrical methods of treatment have unfortunately been taken up more or less by unqualified persons but we should hardly have thought it a politic procedure on the part of the firm in question. We are not surprised to find that protests are being made against such an unjustifiable encroachment upon work which should be confined to medical practitioners.

ROYAL COLLEGE OF SURGEONS OF ENGLAND: HUNTERIAN FESTIVAL.

IN February the anniversary of the birth of John Hunter is celebrated each year at the Royal College of Surgeons of England by the delivery of a Hunterian Oration. This year the oration was delivered by the President of the College, Mr. John Tweedy. It will be found in full in another column and is commented on in a leading article. The oration was followed this year by the Hunterian dinner, which is held biennially, the President being in the chair, supported by the Vice-Presidents, Mr. A. W. Mayo Robson and Mr. Henry T. Butlin. About 100 guests were present, including distinguished representatives of various professions and callings, as will be seen from the following names: the Duke of Abercorn, the Lord Bishop of Oxford, the Dean of Norwich, the Right Hon. James Bryce, M.P., the Hon. Mr. Justice Buckley, the Hon. Mr. Justice A. T. Lawrence, Sir John R. Paget, K.C., General Lord Cheylesmore (Mayor of the City of Westminster), the Vice-Chancellors of the Universities of Cambridge and London, the Dean of the Medical Faculty of the University of London, Sir William Ramsay, F.R.S., the President of the General Medical Council, the President of the British Medical Association, Sir Frederick Bridge, Mus.D., Dr. W. H. Cummings, Mus.D., the Headmaster of Westminster School, Sir Harry H. Johnston, Dr. Edward A. Wilson (surgeon of the National Antarctic Expedition), Sir William S. Church (President of the Royal College of Physicians of London), Sir William H. Broadbent, Sir Lauder Brunton, Sir Dyce Duckworth, Professor T. Clifford Allbutt, Sir Frederick Treves, the Director-General of the Medical Department of the Royal Navy, the Director-General of the Army Medical Service, and the Masters of the Merchant Taylors', Salters', Ironmongers', Clothworkers', Skinners', Leathersellers', Apothecaries', and Grocers' Companies. By a curious coincidence the present Master of the last-named Company is Mr. H. Percivall Pott, a descendant of the well-known surgeon, Percivall Pott, who was one of Hunter's teachers and whose name is still well known in connexion with Pott's fracture. The toast of "The King" was proposed by the President who referred to the great interest taken in the medical profession by the King, as shown by the fact that he was an Honorary Fellow of the Royal College of Surgeons of England and also an Honorary Fellow of the Royal College of Physicians of London. He had too shown his interest, perhaps even in a more important way, by his efforts on behalf of the hospitals of London and by his establishment of King Edward's Hospital Fund which was bringing a spirit of intelligent inquiry to bear upon the hospital administration of London and would, it might be hoped, result in the establishment of a rational system of management and expenditure. In proposing the toast of "Queen Alexandra, the Prince and Princess of Wales, and the other Members of the Royal Family," the President remarked that the Queen was a meet helpmate for His Majesty in all good works and that the Prince of Wales showed his interest in hospital affairs by his presidency of King Edward's Hospital Fund. He also alluded to the position held by His Royal Highness as President of the Cancer Research Fund and referred to his recent speech as showing a remarkable grasp of details connected with the problems with which that Fund had to deal. The toast of "The Memory of John Hunter" was then drunk in silence. Mr. Mayo Robson proposed the toast of "The Visitors" and in coupling with it the names of the Duke of Abercorn and Vice-Admiral W. H. Henderson alluded to the good service that was rendered by the committee established under the auspices of the Duke of Abercorn to our sick and wounded officers. The Duke of Abercorn, in reply, said he was glad of the opportunity—the first that he had had—of returning his cordial thanks to those members of the medical profession who voluntarily and generously gave their skill and their knowledge to help the wounded officers whom it was the object of the fund which he had started to benefit. Vice-Admiral Henderson also responded. The toast of "The President and Orator" was proposed by Sir William Ramsay who spoke of the President as "a man of few words but his words contained wisdom." A short reply by the President brought the proceedings to a close. A programme of music was performed during dinner by the band of H.M. Coldstream Guards.

FRENCH COPYRIGHT IN PROFESSIONAL PHOTOGRAPHS.

ON Feb. 10th judgment was delivered in a French law court in the matter of Dr. Doyen *versus* a firm of photographers. The facts of the case were these. In June, 1898, Dr. Doyen conceived the idea of having certain surgical operations "cinematographed" during their performance. Six different operations were photographed jointly by two photographers, M. Clément Maurice and M. Parnaland. The latter, it is alleged, sold prints from these films to the Société des Phonographes et des Cinématographes and the photographs were publicly sold and even exhibited by showmen (*par des forains*) in public places with Dr. Doyen's name in large letters on the posters. The following were the chief terms of the judgment delivered by the court. The court condemned M. Parnaland and the Société des Phonographes et des Cinématographes jointly to pay to Dr. Doyen the sum of 8000 francs as damages on account of the charges. The court ordered in addition that its judgment should be published in 15 journals to be chosen by Dr. Doyen, provided that the price of each insertion should not exceed the sum of 200 francs. The court also ordered the confiscation and the surrender to the plaintiff of the subjects of the action. This decision is of great importance as it lays down definitely the right of men of science to have absolute control over photographs and other graphic documents which may have been taken in their laboratories. The decision is an altogether new one. Our thanks are due to Dr. Doyen for having provided our Paris correspondent with a copy of the judgment from which we have taken the above facts.

HEMIPLEGIA WITH PARALYSIS OF THE THIRD NERVE ON THE OPPOSITE SIDE DUE TO TUMOUR OF THE TEMPORAL LOBE.

HEMIPLEGIA with paralysis of the third nerve on the opposite side usually indicates a lesion of the crus cerebri implicating the motor tract going to the opposite side and the third nerve on the same side. The fact that this rule is not invariable is shown by the following case reported to the Société Médicale des Hôpitaux of Paris at the meeting of Jan. 13th by M. Menetrier and M. Bloch. A woman, aged 40 years, was admitted to hospital with recurrence of cancer of the left breast. The primary growth was removed a year previously. She was in a somnolent condition and answered repeated questions only by the

monosyllables "yes" and "no." There was right hemiplegia with flaccidity of the muscles and without increase of reflexes. Babinski's sign was well marked. The upper part of the face was but slightly involved in the hemiplegia. There was complete paralysis of the left third nerve—ptosis, external strabismus, mydriasis, and protrusion of the globe. Neither vomiting nor headache was present. The patient became comatose and died. The necropsy showed that the cerebral peduncles were free from any secondary growth. But in the infero-internal part of the left temporal lobe was a tumour of the size of a small apple. It caused the base of the hemisphere to project for several square centimetres, pressed outwards the inferior temporal convolutions, and appeared on the surface between the optic chiasma in front and the cerebral peduncle behind. From the anterior part was a prolongation which compressed the third nerve at the point where it entered the wall of the cavernous sinus. A vertical section through the middle of the tumour and the whole of the cerebral hemisphere showed that the former crossed the fissure of Rolando and extended a considerable distance forwards. It was whitish, firm, of a diameter of four centimetres, and dotted with hæmorrhages. It was in contact with the internal capsule which it compressed. The cerebral peduncle was behind it and quite intact. Thus the crossed paralysis was due to two topographically distinct lesions; the tumour sent forwards an extra-cerebral prolongation from its inferior surface which crushed the third nerve while its upper and intra-cerebral part compressed the internal capsule. In contrast with this case M. Menetrier and M. Bloch referred to another case of cerebral growth secondary to cancer of the breast in which there was crossed paralysis of the third nerve due to a lesion in the usual position. The patient was a woman, aged 56 years, who was operated on for cancer of the left breast. 12 days later she was seized with right hemiplegia with complete paralysis of the left third nerve. The necropsy showed a nodule of cancer in the base of the skull compressing the left cerebral peduncle and left third nerve.

THE FATAL CASE OF PLAGUE IN THE MERSEY.

THE s.s. *Crewe Hall* arrived in the Mersey on Jan. 30th from Rangoon. She was cleared by the Customs officers on the evening of the same day, the captain answering the usual questions and reporting "all well" on board. The ship was rummaged in the river on the following day, the water being too low (14 feet) to allow the vessel to dock. On the morning of Feb. 1st one of the Customs' officers noticed a lascar sick in his bunk, apparently dying. Upon inquiry he was informed that the man had had a severe cold for the previous seven days. He at once notified the port sanitary authority by special messenger and by telephone. This was the first notification which the authority received. Dr. W. Hanna, the assistant medical officer, visited the ship at once and interviewed the captain and the chief steward, the latter having attended and treated the lascar for the previous seven days. They stated that he had had high fever and they thought that he was suffering from malaria; they also mentioned that he had a painful swelling in the groin. The native serang also stated that the man complained of fever and a painful lump in the groin. Dr. Hanna found the man laid out and examined the body in the native sailors' forecastle; all that could be discovered on examination was a large bubo in the left femoral region. On reporting the matter to the port medical officer (Dr. E. W. Hope) the conclusion was arrived at that there was a suspicion of plague in the case and that it would be advisable to treat it as such. Accordingly, the native crew was cleared out of the forecastle, the body was removed, and the bunks and all effects of the native crew were disinfected. The "contacts," 15 in number, after bathing and putting on disinfected clothing, were removed to the port sanitary hospital for isolation. The rat-catchers to the authority were at once notified and visited the vessel but found no dead or sick rats. They set their traps at once and as a result only 11 rats were caught; these were forwarded to Professor R. W. Boyce, the corporation bacteriologist. A further disinfection of all suspected quarters of the ship was undertaken on Feb. 2nd; these have now been repainted. The cargo was discharged under strict supervision and a careful watch was kept for dead rats. Fumigation of the holds to destroy rats was carried out before the vessel sailed. On Feb. 2nd a post-mortem examination of the body of the lascar was made by Dr. Hanna and Dr. A. A. Mussen. There was marked discolouration of the skin over the bubo. The latter was found to be of large size, very hæmorrhagic on section, with much peri-glandular inflammation. There was also evidence of a septicæmic condition with a considerable amount of pneumonia. Material for bacteriological and microscopical examination was taken which was reported on by Dr. Hanna and later confirmed by Professor Boyce and Dr. E. Klein. Microscopically the gland juice showed very numerous plague-like bacilli. On culture (24 hours) a growth typical of the plague bacillus appeared and the organisms as regards appearances and staining reactions answered all the characters of that bacillus. The source of infection in the case of this lascar has up to the present time not been traced but the medical authorities consider the chances of further infection to be very remote.

FLIES AS DISSEMINATORS OF TUBERCULOSIS.

IN 1887 Spillman and Haushalter found tubercle bacilli in the intestinal contents and in the excreta of flies in a hospital ward and Hofmann found the bacilli in flies fed on tuberculous sputum. In the *Boston Medical and Surgical Journal* of Dec. 15th, 1904, Dr. F. T. Lord has published some interesting experiments performed in order to ascertain the part played by flies in disseminating tuberculosis. 30 flies were confined in a glass jar and fed on tuberculous sputum. Within three days 26 died and the remainder had become very inactive. Six flies similarly confined and fed on non-tuberculous sputum died within two days, while four out of six flies fed on water, sugar, and meat were alive at the end of a week. Evidently the short duration of the life of the flies fed on tuberculous sputum was not due to the tubercle bacillus but to some other constituent of the sputum. In sections of these flies tubercle bacilli were found in the intestinal contents but in no other part. Examination of cover glasses placed in the glass jar showed that the bacilli appeared in the excreta within 18 hours and that they had increased in number from an average of ten in a microscopic field of the sputum to 150 in one of the excreta. Each fly-mark contained an average of from 3000 to 5000 bacilli and about 2000 marks had been deposited by the 30 flies in three days, making a total of from 6,000,000 to 10,000,000 bacilli. These bacilli were much larger than those in the sputum and showed some evidence of branching. The jar containing the fly-marks was placed in a room and protected from strong diffused daylight by a board. Guinea-pigs were inoculated in succession with 100 fly-marks which were scraped off at intervals of one, eight, 15, 28, and 55 days. The first inoculation was subcutaneous and the others were intraperitoneal. The animals were killed after from five to seven weeks. Tuberculosis was produced in the first three animals inoculated, showing that virulent bacilli were present in the excreta for at least 15 days. After this time the results were negative. The animal inoculated with the marks which were only a day old showed generalised tuberculosis. In the others the process

was less extensive. Dr. Lord concludes that fly-marks contaminated by tubercle bacilli may be a source of tuberculosis in man for at least 15 days after their deposit if exposed only to diffuse daylight. One way in which the bacilli might be transferred to man is by the contamination of food with the excreta. To determine whether there was any danger of infection by inhalation Dr. Lord exposed guinea-pigs to a gentle current of air drawn through a glass cylinder in which 23 flies were confined with tuberculous sputum and on which they deposited a large number of marks. The animal was killed and showed no trace of tuberculosis. On the other hand, Cornet has shown that guinea-pigs are readily infected when exposed to tuberculous dust. Evidently fly-marks are not a source of danger when merely exposed to a gentle current of air. Dr. Lord observed that flies readily feed on tuberculous sputum even when other food is accessible. If they afterwards alight on human food they may deposit tubercle bacilli in great numbers. It follows that flies should not be allowed access to the sputum of consumptive patients.

"KINDS OF INSANITY."

THE preparation of a new set of statistical tables by the Medico-Psychological Association of Great Britain and Ireland for the annual recording of the vast clinical and pathological data and returns of all public asylums in the future has brought forward the inevitable question of the nomenclature and classification of the insanities. Dr. C. A. Mercier, in an article in the *Journal of Mental Science* for January, deals with the "kinds of insanity" which he thinks fulfil the necessary conditions of true diseases. The arrangement suggested is first to separate congenital from non-congenital cases of insanity. The congenital cases would include all idiots and most imbeciles. The classification of these is a matter of subordinate importance, whereas the division of the insanities proper into natural groups is the main desideratum in mental science and the most important aid to clearness of thought, of diagnosis, and of prognosis. Cases of insanity are proposed to be considered as of two classes—viz., general paralysis (paralytic dementia) and non-paralytic insanity. Dr. Mercier suggests that the latter class contains "diseases sufficiently distinct to merit the same separation that is given to general paralysis. ..... As to general paralysis the symptoms are so distinct that it is recognisable at every stage in its progress. It has a definite history, runs a definite course, and forms a complete clinical picture separable from that of any other case of insanity." Examining other varieties of insanity and their titles or claims to be called diseases, Dr. Mercier would admit "acute delirious mania" owing to its characteristic symptoms and its course as a definite variety of insanity. "The clinical picture of acute delirious mania is distinct and prevents it from being confused with any other cases of insanity. On the contrary," he says, "puerperal insanity presents us with no distinct clinical picture. The very fact that it has been divided into puerperal mania and puerperal melancholia is proof of what I say. Puerperal insanity is acute insanity occurring within an uncertain time of childbirth, and if the antecedent of childbirth is disregarded there is nothing whatever in the clinical picture of the disease that is different from other cases of acute insanity that have no connexion with the puerperium, or even from acute insanity occurring in men." The insanity of pregnancy is regarded as having a much better right to be considered a disease, "for the fact of pregnancy is a continuing feature in the clinical picture, a feature which at once marks off the case from all other cases of insanity." What is true of the insanity of pregnancy, he adds, is emphatically true of the insanity of lactation. It is an insanity of exhaustion—of innutrition—and differs in no respect from other cases of insanity of similar origin. Few cases of insanity occurring at the menopause in women deserve recognition as a separate variety of insanity. Similar cases may occur at other times of life and present the same clinical picture. The definite form of insanity of the menopause "with its special facies" is, says Dr. Mercier, rare. Senile insanity has no right to a special place in nosology. "The term means, it appears, insanity not assigned to any distinct category except by its occurrence in advanced age. It would, in my opinion, be unreasonable to base the differentia of the disease on so slender a foundation." The insanity of epilepsy is admitted to have "a good title to the denomination of a disease." Cases of insanity associated with bodily diseases, whether the latter be regarded as a cause or not, in no case present a clinical picture of sufficient distinctness to entitle them to separate rank as diseases. Dr. Mercier would admit the claims of stupor, paranoia, recurrent and alternating insanity, and the two forms of insanity occurring in adolescents or young adults known as hebephrenia and katatonia. Cases of fixed delusion would also find a place in classification, being further subdivided as the delusions are persecutory, exalted, and personal. Alcoholic insanity would be recognised in its subdivisions of *mania a potu*, delirium tremens (acute forms), or alcoholic insanity proper of the chronic form. This threefold subdivision of alcoholic insanity would exclude all cases in which alcohol was not the main actuating cause of the malady. The above-named varieties of insanity, concludes Dr. Mercier, "have claim to the title of distinct diseases from the distinct clinical pictures they present; all other cases must be lumped together under the heading of insanity *simpliciter*."

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

AT the next meeting of the above society to be held on Tuesday, Feb. 28th, at 8.30 P.M., Sir Frederick Treves will open a discussion on the Subsequent Course and Later History of Cases of Appendicitis after Operation. Sir William Broadbent will speak next in order and other eminent physicians and surgeons have promised to take part in the discussion. Special attention will be directed to the following subjects: 1. The frequency with which complications such as the following occur during convalescence: femoral thrombosis, pulmonary embolism, pylephlebitis and suppuration of the liver, empyema and septic bronchopneumonia, acute intestinal obstruction, residual abscesses, pyosalpinx and suppurating ovaries, and fæcal fistula. 2. The after-results in cases where the appendix has not been removed. 3. What proportion of cases are there in which the symptoms are not relieved by operation or in which recovery is imperfect? Statistical tables have been promised from several hospitals giving information on these points. In view of the many questions to be considered the debate will doubtless be adjourned. It is important that those gentlemen who wish to speak should communicate as soon as possible with the honorary secretaries, 20, Hanover-square, London, W.

THE SARANAC LABORATORY FOR THE STUDY OF TUBERCULOSIS.

WE have received a copy of a publication with the title, "Studies from the Saranac Laboratory for the Study of Tuberculosis, E. L. Trudeau, M.D., Director, 1900–1904." It is published at the office of the *Journal of Medical Research*, 688, Boylston-street, Boston, Massachusetts, U.S.A. It contains several interesting communications, notably the records of a series of observations on the tuberculin reaction by Dr. E. L. Trudeau, Dr. E. R. Baldwin, and Dr. H. M. Kinghorn. The first subject of inquiry was, Can the diagnostic use of tuberculin scatter

the disease and produce new tuberculous foci? This is an important point, as tuberculin is employed for diagnostic purposes not only in relation to cattle but also in actual medical practice. The detection of a partial reaction enables the necessary treatment to be carried out at a stage of the disease in which the prospects of treatment are very favourable. In localised corneal tuberculosis of the rabbit's eye no spread of the disease in the cornea could be observed after the use of tuberculin injections. On the contrary, a favourable absorptive influence was noted upon the diseased focus. From other investigations it was concluded the specific tubercles must be present in order that a local tuberculin reaction could be manifested. It was, however, demonstrated that local reactions with rise of temperature occasionally resulted from the injection of trypsin, peptone, and sodium cinnamate. These reactions were not uniform and only took place when large doses were injected. Except in fatal poisoning by peptone the reactions did not bear a close resemblance to the typical tuberculin reaction. It is possible that the mixture of albumoses, known as peptone, contains proteid substances chemically similar to tuberculin, the injection of which excites a more or less marked reaction in the tuberculous tissue according to "the age and sensitiveness of the tubercles." Some valuable work is evidently being accomplished in the Saranac laboratory and doubtless further results will in due time be published.

THE DANGERS OF FLANNELETTE.

OUR Manchester correspondent writes: You and your readers may perhaps be weary of the subject of flannelette, but the death-roll, the result of its use, is so heavy as to excuse the mention of two cases that have just occurred here. One child, four years old, was left alone for a few minutes when her clothes caught fire and she was fatally burnt. The other case was very similar. The child was dressed in flannelette, left for five minutes, and when the mother returned was found enveloped in flames which she could not extinguish. The city coroner has often spoken of the danger of this material and has consequently been accused of trying "to rob the poor of their cheap and warm covering." The non-inflammable variety is said to be obtainable at 2½*d*. per yard. There is, moreover, another safeguard the use of which has been strongly urged by the coroners of Warrington and Lancaster. The latter said that the investment of 1*s*. 6*d*. in a fireguard was better than an investment with the undertaker after a child had died a terrible death. And the former said just before Christmas that he had held 14 inquests this winter on children who had been burned, fireguards having been absent in every case. From this gentleman's statement it would seem that callousness and indifference are not confined to the social stratum in which these occurrences usually take place. He said "it was no use making representations to the county council when they sneered at them and the chairman said it would be grandmotherly legislation to adopt their suggestions." These tragedies, he said, "occurred among a class of people who brought children into the world and were absolutely indifferent to their education, physical culture, and welfare, and upon whom no moral suasion had any effect. The legislature should compel them to do what they ought to do." This is a severe accusation to make but though, happily, there are exceptions, those who know most about the matter must acknowledge its truth.

THE JENNER SOCIETY.

HARDLY any fact in epidemiology is better attested than the efficacy of recent vaccination in conferring immunity from small-pox and as it is well known that the protection gradually wears off in the course of years revaccination at proper intervals is essential for safety. In its report of the period from July 1st, 1903, to Dec. 31st, 1904, the executive committee of the Jenner Society expresses regret that the Government has not seen its way to give facilities for introducing a Revaccination Bill and in a subsequent paragraph the report alludes to the influences by which Members of Parliament are likely to be deterred from supporting such a measure. The working classes, with whom the voting power of the constituencies resides, do not recognise the advantages of vaccination and are sometimes actively hostile to the practice. "For such a state of things there is only one remedy, and that is education." The society acts up to its own precepts by liberal distribution of leaflets, pamphlets, and other forms of literature in favour of vaccination, specimens of which may be obtained from the honorary secretary of the society, Dr. Francis T. Bond of Gloucester. In some of these the arguments are strengthened by well-executed photographs showing the marked contrast between modified and unmodified small-pox. Some administrative defects connected with the existing system of vaccination are commented on and the report, which is signed by the Dean of Gloucester, closes with the remark that much remains to be done which the society is unable to attempt for want of funds.

THE MAGNET IN OPHTHALMIC SURGERY.

IN three important articles contributed to our contemporary the *Ophthalmoscope* Professor J. Hirschberg of Berlin, Professor O. Haab of Zürich, and Mr. S. Snell of University College, Sheffield, give the results of their experience in treating cases of accident where fragments of iron have penetrated the eye and are lodged in its tissues. Statistics of a valuable nature can, of course, only be obtained by those who are practising in large cities, or at least in towns where there are numerous trades engaged in, or associated with, metallurgical processes and in the varied occupations where filing, rivetting, hammering, and the manufacture of tools engage the attention of workmen. Professor Hirschberg informs us that there are 50,000 iron-workers in Berlin and that in the course of the last 25 years he has performed 307 operations with the magnet. Professor Haab has had more than 200 cases during the last 12 years under his care and Mr. Snell has had fully 300 instances in which the electromagnet has been employed. It is justifiable to draw some general conclusions in regard to the utility of the magnet in ophthalmic surgery from 800 cases. In the first place, the general statement may be made that fragments of iron or steel should never be allowed to remain imbedded in the tissues of the eye. Even though they appear to excite no inflammation and are not productive of pain, slow changes are set up which ultimately lead to the impairment of vision. Professor Hirschberg records one remarkable case in which a splinter of iron penetrated the eye and lodged in the retina of a man with preservation of almost normal vision, yet on having the opportunity of again examining the patient after 28 years Professor Hirschberg found that he had become blind from cataract and cyclitis a year after the accident. In the next place, the presence and position of the fragment should be carefully ascertained by naked-eye inspection, by oblique illumination, by the ophthalmoscope, or by means of the sideroscope, or by radiography; its location being determined by one or other of these means so far as possible with precision, the form of magnet to be used and the mode in which it should be applied with the least harm to the patient and the best prospect of success in removing the splinter, should be taken into consideration. Where the fragment is small and superficially situated, as in the anterior chamber or imbedded in the iris, it may sometimes be extracted through the corneal wound with a hand magnet,

but if it be deeply situated or firmly fixed a stronger instrument is commonly required and then one or other of the giant magnets devised by the authorities above mentioned should be employed. It must not, however, be supposed that this is an easy matter or one to be undertaken in an offhand manner. By Professor Haab, who first devised the giant magnet, it is pointed out that inasmuch as the pull upon the splinter on the application of the instrument is apt to give pain and to cause the fragment to be pressed violently into the ciliary region, whence it is not easy to disengage it, the patient should not be placed on a couch with the head fixed but that he should sit upright and thus be able to withdraw his head when pain is felt. Professor Haab thinks that the electric current should by a movement of the foot be switched on or off in order that the splinter may be moved by a series of jerks. At the same time the overheating of the pole introduced into the eye should be avoided. He holds, moreover, that the intruding substance on making its way out, if it be deeply implanted in the vitreous, does not follow the way of entrance but the lines of power of the magnetic force. Hence it slides almost regularly around the lens and appears behind the iris and when it has gained this position the patient should be so placed that the point or pole of the magnet is opposite the middle of the cornea. As Mr. W. Lang suggests, a steel spud may then be introduced into the anterior chamber, the base of the spatula being connected with Haab's magnet by means of a few strands of soft iron wire, and the particle clinging to it is then readily removed through the corneal opening. Iridectomy should be rarely performed. Mr. Snell, who first suggested the employment of an electro-magnet in ophthalmic surgery so long ago as 1881, has by one or two slight modifications of his original instrument designed an extremely useful and handy form of magnet well adapted for all ordinary emergencies. It is now in common use in this country. When attached to a quart bichromate battery it is capable of raising and of holding suspended a weight of at least seven ounces. He contends that the smaller instrument which he employs possesses distinct advantages over the giant magnet. It is more easily handled, more portable, and far less expensive. Where failure to remove the foreign body occurs on the first attempt, Professor Haab states that he has been successful after two or three trials. It is to be noticed that a large proportion of these accidents, perhaps half, are followed by cataract. Mr. Snell gives some interesting statistics, showing that in by far the larger number of cases the splinter is lodged in the vitreous, the size varying from small particles to fragments weighing 36, 32, and 22 grains.

THE medical officer of health of the Cape Colony states that for the week ending Jan. 21st the condition of the colony as regards plague was as follows. No case of plague in human beings was discovered during the week but plague-infected rodents were found at Port Elizabeth and East London, together with 2 plague-infected cats at the latter place. In other districts no case of plague in either man or other animal was discovered.

A DISCUSSION will be opened on Saturday, March 4th, in the Council Chamber, Town Hall, Newcastle-upon-Tyne, on the Aerial Dissemination of Small-pox round Hospitals, by Dr. Henry E. Armstrong. The chair will be taken at 11 A.M. by Mr. W. Whitaker, F.R.S., F.G.S., chairman of the council of the Royal Sanitary Institute, under the auspices of which the discussion has been arranged.

A MEETING of the Hospitals Association will be held on Friday, March 3rd, in the hall of Charing Cross Hospital, at 8 P.M. Mr. Thomas Bryant will occupy the chair. A paper will be read by Dr. Donald J. Mackintosh, medical superintendent of the Glasgow Western Infirmary, on the Control of Hospital Expenditure with Efficiency.

THE annual meeting of the After-Care Association, which exists to look after the interests of poor persons discharged recovered from asylums for the insane, will be held at 52, Wimpole-street, London, W., by kind permission of Dr. and Mrs. Harrington Sainsbury, on Wednesday next, Feb. 22nd, at 2.45 P.M. The Bishop of St. Albans will preside.

AT the Harveian Society of London, Stafford Rooms, Titchborne-street, Edgware-road, W., on March 9th, at 8.30 P.M., Mr. Malcolm A. Morris will deliver the Harveian lecture on Some Modern Therapeutic Methods in Dermatology, with exhibition of cases treated by the x and the Finsen rays.

THE dinner in honour of the celebration of the hundredth anniversary of the birth of Señor Manuel Garcia will take place on March 17th, at 7.30 P.M., at the Hotel Cecil.

Sir Michael Foster has decided to offer himself for re-election to the next Parliament as Member for the University of London. He seeks re-election as a representative of science and higher education; if re-elected he will take his seat as a member of the Liberal party. A committee, with Sir Thomas Barlow as chairman, has been formed to promote his election. This committee comprises graduates belonging to different political parties who are supporting Sir Michael Foster on the ground of his many public services and in the belief that his special knowledge will continue to prove of great value to the House of Commons.

THE epidemic of typhoid fever at Lincoln is assuming serious proportions. Over 500 cases have been reported, with 30 deaths.

MEDICINE, ITS PRACTICE AND ITS PUBLIC RELATIONS.

CHAPTER I.

PRELIMINARY EDITORIAL NOTE.

WE propose in a series of articles under the title of Medicine, its Practice and its Public Relations, to present to our readers a picture of the present position of the medical profession considered especially with regard to the existing conditions of society at large in this country. The articles have been written by a member of our staff and must not be regarded as the last editorial word upon questions some of which are complex and many of which are vexed. That we are prepared to issue the series must be accepted as a proof that we consider the writer well equipped for his task as well as in the main sound in his conclusions, while the greater part of his facts will be found scattered through our columns. The bringing together of these facts in a systematic way and their presentation as a whole with due regard to their individual importance cannot fail to be valuable to our readers, for such a *résumé* will serve both as a report upon matters of common knowledge and opinion which will save much wearisome work of reference, and, at the same time, as material for debate where subjects of dispute are touched upon. The utility of debate depends largely, almost wholly, upon a clear understanding of what are the points to be debated and in the critical period of our social history that is now with us it is of the first importance that medical men should know exactly what it is that makes the times out of joint before discussing the proper remedies

for the reduction of the dislocations. There is no doubt that the profession of medicine has of recent years made vast strides forward scientifically, yet medical education was never more subjected to adverse criticism. In many respects the life of the medical man of the present day, in whatsoever sphere he is called upon to exercise his calling, is a more dignified one than it was half a century ago, yet never were the hardships and injustices of our career more obvious or more roundly resented. The chapters which will follow deal with the professional life of the British medical man in all its different phases and are intended to summarise and to appreciate at their proper worth the various grievances which undoubtedly prevail. We are certain that those of our readers who have the interests of the medical profession at heart will find such a work valuable. Where they agree with the writer their opinions will be reinforced; where they disagree they can decide, after any discussion which may seem necessary, either to maintain or to qualify their views. In either case they will be compelled to think what those views really are and upon what logical grounds they are founded, a form of contemplative attention which the social side of the medical career seldom receives.

Nothing has of late been more marked in the vital scheme of this country than the destruction of tradition. The spirit which was once wont to estimate as an act of impiety any effort to improve upon the methods of our grandfathers is well-nigh extinct among all classes, however varied their intellectual equipment, their religions, or their position; and, as a matter of course, the profession of medicine has shared in the general striving for improvement. A striving for improvement is, however, apt in the first instance to lead to muddle and discord. Reforms are advocated for which the world is not ready, extreme remedies are recommended for conditions that are not so parlous as they appear. The policies of reformers become to some extent discredited, as their efforts, however well-directed, are largely nullified by the obvious impracticability of some of their proposals. It is necessary, if the medical profession is to formulate for its guidance and improvement any general scheme of reform, not only that the grievances complained of should be verified as actually existing but that the possibility of their removal should also be demonstrated. The series of articles will discuss the grievances of the medical profession as a whole, those of consulting physicians and surgeons, those of general practitioners, and those of the staffs of the naval, military, colonial, and civil services. The conditions of employment, the average rates of emolument, the meanings of these rates when compared with the earnings of other professions, will have to be considered and in this way it will be possible to ascertain the following: (1) what things are certainly hardships which it is the duty of every one of us to strive to remove; (2) what things are expressions of faults in our general social scheme, where the duty of finding a remedy can hardly be said to devolve on the medical profession alone but rather belongs to the whole body politic; and (3) what things cannot be said to be general professional grievances at all, although in individual instances members of the medical profession may be oppressed by them. It is usual for us to receive weekly, and during the sessions of the General Medical Council it is invariable for us to receive daily, communications from readers calling attention to the inactivity or lack of sympathy of the controlling body of the medical profession. Almost without exception these communications are sent to us by persons who have not in their minds a clear conception of what the duties of the General Medical Council are. They do not realise either the vast scope of the work of that body in some directions or its limitations in others, and as a rule they regard the Council as a body existing for the support and protection of the medical profession rather than as a body whose duty lies wholly towards the public, inasmuch as the reason of its existence is simply to guarantee that the public is served by a properly equipped, properly educated, and properly behaved body of medical men. The series therefore fitly commences with a brief statement of the duties and scope of the General Medical Council, passing on to the general and the special grievances of the medical profession. The overwork in some branches of our profession and the underpay in others are noticed, as is the inequality of the distribution of our medical service whereby vast districts—vast, that is, in comparison with the size of these islands—are left without medical service, while other communities have such a choice of professional assistance offered to them that all the evils of over-competition spring up and menace the amenities of professional life. It will be necessary in such cases to consider the remedies and it cannot be too definitely and certainly stated that the more altruistic the programme of reform is which may be adopted by the medical profession the more practical it will be. All over the civilised world the life of the medical man is recognised as adorned by self-sacrifice. In all countries the medical man is expected to place his services at the disposal of the sick, sparing not time or talents or strength in his endeavours to relieve pain or to save life and giving no thought to reward. No other professional man is placed in the position towards his fellows that the medical man occupies, because those who need the services of a medical man have claims the elementary simplicity of which are recognisable by all. A man may want to go to law or to build a bridge, he may want to do either thing most urgently, but no one will call either the solicitor or the engineer inhuman if he is not prepared to give his professional services immediately and gratuitously where the applicant is without means. Yet not only unprotestingly but with alacrity the medical man does his best for the poor, the claims of pain and sickness being paramount over all personal considerations. It is natural, therefore, that the medical profession should expect that the public which it serves in so ungrudging a manner should be willing to see the calling of medicine placed upon a secure and dignified basis. But this expectation must be suppressed. No attention whatever will be paid by the public at large or by the legislative councils of the country to any such claim, and every scheme for the improvement of the medical profession must be honestly founded upon principles that would work to the advantage of the public. There should be no difficulty about the matter. It is clearly in the interests of the public to be served by capable men happy in the exercise of their talents and happy in the dignity of their calling, and medical men should ask only for the public recognition thus implied.

The training of the medical student is a matter of the first importance in a consideration of the state of the medical profession. In respect to medical education, the debates which have during the last two or three years taken place at the sessions of the General Medical Council show how increasing are the difficulties here. Medical science is advancing by geometrical progression, encroaching in every direction upon provinces which were wont to be considered as definitely allocated to other sciences. Similarly the public at large is vastly improved in general knowledge and requires of those who advise it, whether in theology, law, medicine, or what not, some recognition of this fact. The professional man can no longer out of his superior learning counsel his clients dogmatically or empirically; so that from the mere circumstance that the public is better mentally equipped it is necessary that the education of the medical man should be wider—that is to say, that for the medical man at the present day a larger general culture is required in addition to a more complicated

and elaborate professional equipment. How, then, is time to be found for the student to learn even the bare irreducible minimum of what he must learn? or, to get a little further back, what constitutes the irreducible minimum for which time must be found during its acquisition? Here the question is at once obscured by the fact that in the United Kingdom many different examining bodies provide separate schemes of education for medical students, the coördinating authority being the General Medical Council, whose duty it is to see that the qualifying examinations of the various bodies are properly conducted and properly standardised. Nor is the multiplication of educational boards and systems the only difficulty. It is an unfortunate fact that the limits of the authority of the General Medical Council are ill defined, some of the qualifying bodies believing that the Council has not the powers which it claims, so that the extent to which a central control really exists, so far as medical education is concerned, is somewhat a matter of doubt. The General Medical Council can, and does, prevent the evils to the public at large which would result from a down-grade competition between the qualifying bodies, but that it possesses much more coördinating influence than is thus proven appears doubtful. A very considerable easing of the situation would be effected by the creation of a one-portal system whereby every medical man in the United Kingdom would enter the medical profession after the passing of one and the same set of tests. This one-portal system has been advocated at different times by THE LANCET and is again to be advocated in these articles. Times have changed since we in these pages urged the one-portal system as a remedy for most of the existing abuses. Had the system then been adopted we have no hesitation in saying that one of the most obvious grievances in the medical profession would never have sprung into being, for we should not see the London medical student placed in an apparently inferior position to the Scotch or Irish or provincial student of similar attainments. The fact remains, however, that the one-portal system did not commend itself sufficiently to the country at large to obtain legislative support and the chances of obtaining it now are, we fear, very small. But advocacy of its adoption will serve a good purpose—the matter should be threshed out if only to prevent the eternal shelving of questions of reform. If, after mature consideration and debate, the idea of securing a one-portal system in this country appears completely ideal it will save time that we should frankly admit the fact, when abuses that are supposed to be waiting alleviation until the good time when the one-portal system comes into being will be tackled from other aspects. On these matters our endorsement of the writer's views can only be regarded as general, our hope in publishing them being to elicit some solidarity of opinion among medical men upon the matter. It is, in fact, this solidarity of opinion, this real union of medical men, that we want to see created. We want those medical men who take pride in their calling to think for themselves what the present sociology of medicine is, to note where the calling of medicine is out of touch with the times and the general polity of this country, and to appreciate what are its undeniable disabilities and how far they can be practically remedied, not only without trenching upon the rights of the public at large but actually with benefit to that public through the resulting supply of a finer quality of service.

ASYLUM REPORTS.

London County Epileptic Colony, Ewell (Report for the year ending March 31st, 1904).—The colony was formally opened under happy auspices on July 1st, 1903,[1] when on the occasion of the visit of H.R.H. Princess Louise, Duchess of Fife, and in the presence of the chairman of the London County Council and a large assembly of visitors, the opening ceremony was performed by the Duke of Fife. A handsome brass tablet has been placed in the entrance hall to mark the occasion. This therefore is the first report. The colony owes its origin to the fact that the asylums committee of the London County Council was impressed with the knowledge that among the epileptics housed in its asylums there were some 300 patients whose disease was mild in character and who seemed suitable to enjoy the benefits of colony or farm life. Accordingly an estate of 112 acres was purchased near Ewell, Epsom, on which a system of villas and buildings of a suitable character were erected. All the villas are of a one-storeyed character and provide accommodation each for 38 patients. The warming and ventilation are on the latest approved pattern and the buildings are lighted throughout by electricity. Roads have been made and gardens planted, the gardens of the villas being separated by earth banks or belts of planted trees and shrubs, so that ingress and egress are found only by the paths. The total number of patients admitted during the year was 315, comprising 250 males and 65 females. During the year the death-rate was low, there being only 17 deaths (14 males and three females). The medical superintendent, Dr. C. H. Bond, states in his report that private cases are admitted but that as the number of such cases received has been small "there still remains one villa not yet in occupation." The necessity of vigilance in regard to the class of patients is emphasised. Thus of the 315 cases sent to the colony 80, or 25 per cent., had at one time or another in their history been regarded as suicidal. The table of admissions shows a faulty (neurotic or insane) heredity in nearly 50 per cent. of cases, distributed as follows: 19 per cent. of cases of insane heredity, 17 per cent. of epileptic heredity, and 10 per cent. of alcoholic heredity. "A well-defined history of trauma, in the form of either injuries to the head or severe falls productive of shock, was found in as large a proportion as 14 per cent." Arterio-sclerosis was present in 14 per cent. of the admissions. Farm and garden work is systematically and daily taken part in by the patients, while the grounds are freely open for all to stroll about in during the intervals. "In a few instances the character of the men's labour is really that of skilled workmen, in about a third it is of fair value, but in the case of the majority it is crude and that of men entirely unaccustomed to agricultural pursuits." The patients are under regular medicinal treatment which includes bromide of strontium and a specially regulated diet. Cricket and other games are provided. The Commissioners in Lunacy state that the colony consists of able-bodied working epileptics, that the buildings are well constructed and suitable to their purpose, that the colonists were neatly clad and looked in good health, and that satisfactory progress has been made in the colony during the first year of its existence.

[1] An account of the opening appeared in THE LANCET of July 11th, 1903, p. 110.

"LA MÉTAPSYCHIQUE."

ALTHOUGH opinions differ as to the soundness of the hypotheses discussed at the meetings of the Society for Psychical Research, there is no denying that the society has secured the active sympathy and coöperation of several eminent authorities in orthodox physical and biological science. At the annual general meeting held at 20, Hanover-square, London, W., on Feb. 6th, an address was delivered by the newly elected president, M. Charles Richet, professor of physiology in the Paris Faculty of Medicine. The proceedings commenced with some brief remarks by the retiring president, Mr. W. F. Barrett, F.R.S., professor of physics in the Royal College of Science of Ireland. Professor Barrett said that the acceptance of the chair by Professor Richet marked an epoch in the history of the society and was also a token of international amity. Professor Richet was a courageous defender of truths which "official science" still regarded with disdain and it was discreditable that science had shown such hostility, not only to the recognition but even to the investigation of supernatural phenomena. Professor Richet, who spoke in French for about an hour, delivered an address which was

admirable from the rhetorical, apologetic, and argumentative point of view. Before proceeding very far he made a practical suggestion of obvious value—namely, that a hand-book dealing synthetically with the immense accumulation of recorded facts was a great desideratum. All branches of knowledge were defined and described in treatises which were useful, not only for reference but for the instruction of beginners, and occult science ought to be in possession of similar advantages. "Occult science" was, however, itself an unsatisfactory term, for all sciences at their outset were occult and remained more or less in that condition until they ultimately became exact. After reviewing the objections which attach to the terms "psychical science," "spiritistic science," and the risk of a partial confusion between the words psychical and psychological, he proposed the adoption of the newly-coined designation "la métapsychique." In the proposed text-book metapsychical phenomena would be classified according as they were either (1) purely psychic, involving no vibration or movement of matter; or (2) purely material. Premonitions and telepathy were examples of purely psychic phenomena, while raps, materialisations, passage of solid substances through other solid substances, and levitation were examples of material or mechanical phenomena. Questions relating to raps, luminous phenomena, spirit photography, and clairvoyance were next discussed at much length. In conclusion, Professor Richet said that while he had no doubt as to the reality of many of the phenomena he thought that no satisfactory explanation had as yet been suggested. An explanation would, however, be found some time or other, just as the planetary motions had been observed before they were explained by Kepler and electrical phenomena before they were explained by Ampère, Faraday, Clerk Maxwell, and Hertz. A vote of thanks to Professor Richet for his address was proposed by Sir Oliver Lodge, seconded by the Hon. Everett Fielding, and carried by acclamation in a crowded meeting.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

AN ordinary meeting of the Council was held on Feb. 9th, Mr. JOHN TWEEDY, the President, being in the chair.

The death in his ninetieth year of Mr. Luther Holden was reported. He was past president and past member of the Council and of the Court of Examiners. He was also senior Fellow of the College. A resolution was passed expressing sympathy with Mrs. Holden and recording the Council's appreciation of his services to the College.

Diplomas of Membership were granted to 99 successful candidates and diplomas in dental surgery were issued to nine candidates found qualified in dental surgery.

It was also resolved to issue jointly with the Royal College of Physicians of London diplomas in public health to 17 successful candidates.

Mr. W. H. A. Jacobson was re-elected and Mr. Bilton Pollard was elected a member of the Court of Examiners. Mr. Thomas Bryant was reappointed to represent the College on the council of Queen's Victoria Jubilee Institute for Nurses for three years.

It was resolved—

That a committee be appointed to consider and report upon the practicability of the institution by the College of a school for the teaching of the early and intermediate subjects of the medical curriculum and of advanced pathology.

A letter was read from Mrs. Silcock thanking the Council for the expression of its sympathy with her in the loss of her husband.

Dr. J. Ward Cousins was reappointed the representative of the College on the Central Midwives Board.

A letter was read from the President and the general secretary of the Fifteenth International Congress of Medicine to be held at Lisbon in April, 1906, asking the College to send a representative to the Congress and expressing the hope that they may be able to announce the adhesion of the College to the Congress in the next number of the official programme. It was resolved that a representative should be sent but the selection was postponed to a later date.

Obituary.

LUTHER HOLDEN, F.R.C.S. ENG.,

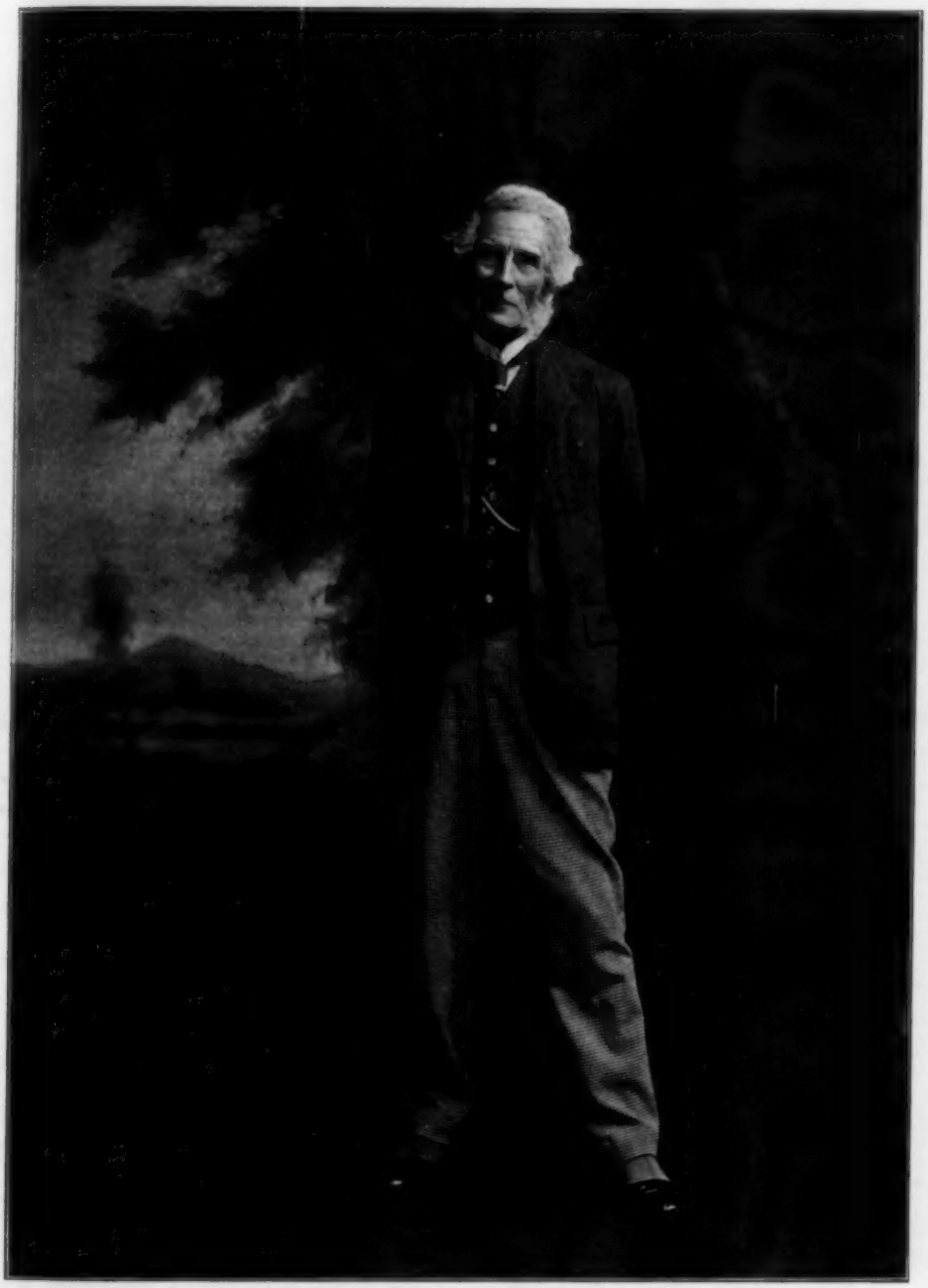
CONSULTING SURGEON, ST. BARTHOLOMEW'S HOSPITAL.

MANY generations of St. Bartholomew's men will have heard with regret of the death on Feb. 6th, in his ninetieth year, of Luther Holden, consulting surgeon to the hospital. He came of an old Staffordshire family, being the second son of the Rev. Henry Augustus Holden, and was born in Birmingham on Dec. 19th, 1815. His elder brother, the Rev. Henry Holden, D.D., honorary canon of Durham, is still alive and is in his ninety-first year, having been born on July 7th, 1814. Luther Holden's father was assistant curate at Wolstanton in Shropshire where, among other duties, he educated his son Luther, and it having been determined that Luther should follow the medical profession, he was, when about 17 years old, apprenticed to Stanley, then one of the surgeons at St. Bartholomew's Hospital. Besides studying in London Holden resided for a year in Berlin and for another year in Paris, reaping there the benefits of the French method of teaching anatomy, which was in those days far superior to that of other countries.

In 1838 Holden became a Member of the Royal College of Surgeons of England and was for some years engaged in teaching anatomy to students of St. Bartholomew's in the dissecting room, although he held no official position at the hospital. On Christmas Eve, 1844, he was elected a Fellow of the Royal College of Surgeons after the first examination held for this diploma. His first official connexion with the school of the hospital was in 1845 when, as appears by the issue of THE LANCET of Sept. 27th of that year (the "Student's Number"), he was appointed as superintendent of dissections, his colleague being Mr. McWhinnie. In 1859 we find him noted as lecturer upon descriptive and surgical anatomy, his colleague being Mr. Skey. In the year 1860 he attained the wish of his heart, being elected assistant surgeon, his age being then 45 years. There were then four surgeons—namely, Lawrence, Stanley, Lloyd, and Skey, the assistant surgeons being Wormald, Paget, McWhinnie, and Coote. Holden became assistant surgeon to Skey. Between 1860 and 1865 all the four senior surgeons retired and Holden became full surgeon in 1865, taking for his assistant Alfred Willett, now a consulting surgeon to the hospital. Holden served for 15 years as surgeon, retiring under the age limit in 1881. He never cared about private practice and consequently did but little.

Holden's work in anatomy was chiefly limited to educational work but in 1850 he read a paper before the Abernethian Society of St. Bartholomew's Hospital on the mechanism of the hip-joint which referred to the influence of the pressure of the atmosphere in retaining the head of the femur within the acetabulum and also to the important part which the anterior portion of the capsular ligament played with regard to the erect attitude of the body. In 1851 there appeared his "Manual of the Dissection of the Human Body."

In 1855 was published the book by which Holden was known to nearly every medical student in the kingdom—viz., his "Human Osteology." It was magnificently illustrated by Holden himself and was the first book in which the now universally used system was employed of marking the origin and insertion of the muscles by means of red and blue lines. When it appeared the reviews generally contained the remark "Why did no one think of this before?" and it may be said that practically every work on osteology which has appeared since has followed the same plan for indicating muscular attachments. Moreover, the late Sir William Flower, when Conservator of the Royal College of Surgeons of England, adopted it for the marking of mounted specimens. Another admirable work by Holden was his "Landmarks, Medical and Surgical," which made its first appearance in 1866 as an article in the St. Bartholomew's Hospital Reports for that year. A further portion of the work appeared in the reports for 1870 and in 1876 it was published as a separate book. As may be gathered from the title it taught the student how



LUTHER HOLDEN, F.R.C.S.

great was the amount of anatomy that he could learn on the surface of the living body while the skin was yet unbroken.

Throughout his long life Holden was very much to the fore in the Royal College of Surgeons. He was elected a Member of the Council in 1868, his two colleagues being John Simon and George Murray Humphry. In 1873 he was elected a member of the Court of Examiners, together with John Marshall and Timothy Holmes, and in 1875 he was elected a member of the Board of Examiners in Anatomy and Physiology, among his colleagues being William Scovell Savory, John Birkett, John Wood, Henry Power, and Christopher Heath. In 1879 he was elected President of the College, having been a Vice-President for the two previous years. In 1881 he delivered the Hunterian oration. In this discourse, owing to careful research into the history of Hunter's earlier years, the orator was enabled to vindicate the great man from the charge which has been brought by so many former biographers of being during his youth inclined to waywardness, indolence, and dissipation. Moreover, in view of a present-day controversy, it is interesting to note that Holden concluded his oration by dwelling on the advantage of a classical training for medical students, stating that as an old teacher he found that those pupils who had received a good public school training could be taught more in two months than others in six. He urged that the youths who were to be the future representatives of English surgery should not be looked upon as "symbols" of an inferior education.

It is worthy of note that Luther Holden died in his ninetieth year, that he has a brother still living who is in his ninety-first year, and that the father and the mother of these two brothers were first-cousins. Luther Holden was a man of striking appearance. He was very tall and marvellously young for his years, carried himself very upright, and walked like a young man. He was always neatly dressed and markedly well turned out, and used to say himself, "I keep my youth by always being about with young people." After his retirement he took to travelling and went nearly all over the world—to Japan, South Africa, South America, and Australia. He was in Johannesburg in 1898 and when he came home he said, "Kruger won't live long, he's got emphysema and granular kidney." Wherever he went he was welcome and used to be entertained at dinner by old St. Bartholomew's men in out-of-the-way places. Luther Holden was twice married and when at home lived the life of a country gentleman on a small estate near Ipswich.

His body was interred in the cemetery of the parish church, Upminster, on Friday, Feb. 10th, the Rev. Hyla Holden, rector, officiating. The Royal College of Surgeons of England was represented by Mr. John Langton and St. Bartholomew's Hospital by Sir Dyce Duckworth and Mr. Harrison Cripps. Mr. T. B. Archer, Mr. Alban Doran (former house surgeons to Mr. Holden), Dr. J. H. Stowers, Dr. G. H. R. Holden of Reading, and many other relatives and friends of the deceased were present.

NATHANIEL DAVIDSON, L.R.C.P. LOND., L.R.C.S. EDIN., L.S.A.

ON Feb. 9th, at 11, Bentinck-terrace, Albert-road, London, N.W., one of the oldest members of the medical profession passed away in the person of Mr. Nathaniel Davidson. He was born in 1805 and would have completed his century if he had survived to the month of March. Mr. Davidson was educated at Edinburgh and took the Licence of the Royal College of Surgeons of Edinburgh in 1828. Coming to London he took the Licence of the Society of Apothecaries in 1829 and practised for many years in George-street, Portman-square. In 1861 he obtained the Licence of the Royal College of Physicians of London. The funeral took place at Shanklin, Isle of Wight, on Feb. 14th.

DEATHS OF EMINENT FOREIGN MEDICAL MEN.—The deaths of the following eminent foreign medical men are announced:—Dr. Gustave Piotrowski, *privat-docent* of physiology in the University of Lemberg.—Dr. I. Felix, formerly professor of hygiene in the Bucharest School of Medicine.—Dr. J. A. Serrano, professor of anatomy in the Lisbon medical school.—Dr. Gustav Ludwig, who was formerly physician to the German Hospital, London. Some ten years ago his health obliged him to give up practice and after travelling a good deal he settled down in Venice where he was able to enjoy his very considerable artistic and antiquarian collections.

MEDICINE AND THE LAW.

Analysts' Certificates under the Sale of Food and Drugs Acts.

AN appeal of an interesting character was recently heard in the Divisional Court with regard to an analyst's certificate in a case relating to the adulteration of milk. The certificate impugned was as follows:—

> I am of opinion that the sample contained the parts as under: Milk-fat, 1·4 per cent.; milk solids other than milk-fat, 5·6 per cent. Observations.—This milk is deficient in milk solids other than milk-fat to the extent of 2·9 per cent., which is equivalent to the addition of 34·2 per cent. of water. It is also deficient in milk-fat to the extent of 53·4 per cent. of the milk-fat.

The justices had dismissed the charge on the ground that the certificate was bad in that it did not state the standard upon which it was based. The court dissented from this view after hearing argument on behalf of the public authority and ordered the case to be remitted to the magistrates. The Lord Chief Justice in giving judgment said that although the certificate showed that the milk had been compared with some standard it would have been more correct to state in it distinctly what the proper quantity of milk-fat was. Examination would reveal that this did appear from the certificate, or in other words "the standard of calculation could be gathered from the certificate itself," and for this reason the appeal was allowed. In agreeing with his lordship's view Mr. Justice Kennedy pointed out that it is important that the accused should know without elaborate calculations what he is accused of and he expressed the hope that those who gave certificates would err, if at all, on the side of fulness and simplicity. It is hardly necessary to add to this that the certificates of analysts in prosecutions under the Sale of Food and Drugs Acts are carefully scrutinised by the defence, not only in order to defeat the prosecution on technical grounds but in order that the defendant may be able to meet, if possible, the case raised against him and the objections to the form of the certificate are often made because it states too little, never because it says too much.

A Question of Professional Secrecy.

A paper read recently before the Obstetrical Society of Cincinnati, U.S.A., by Dr. E. S. McKee, had for its title "The Ethics of Gonorrhœa in the Female" and for its subject the difficulties which may beset the medical man in preserving the secrets of his patient consistently with his duty to society where venereal disease in a woman is concerned. In a case of this kind it is hardly necessary to point out that the knowledge acquired by the medical practitioner in the exercise of his profession is not confined to the fact that his patient suffers from a disease. It may place her reputation in his keeping, so that it is in his power to destroy it, or circumstances may come under his observation during his treatment of her which may render him the one person who can effectively maintain her honour. On some occasions, again, he may acquire the secret of the dishonour of a man or of a woman other than his patient. In short, the complications that may arise are numerous and each case must be dealt with according to its merits, always keeping in mind certain broad principles of professional conduct. In the paper referred to a curious instance is given of a case in which the duty of the medical man was not altogether clear and in which he had a legal decision to guide him with which he did not agree. A young man came to Dr. McKee and confessed that he had infected his wife with gonorrhœa. Dr. McKee successfully treated her for it. Meanwhile the husband confessed to his wife also what he had done and apparently allowed her to infer that her medical attendant knew to whom her disease was due. Later on divorce proceedings were initiated by the wife and Dr. McKee received the United States equivalent to a subpœna, a somewhat drastic form of summons enforced by the presence of a constable, to come and testify to what the husband had told him. This he declined to do. The American law accords privilege to knowledge obtained from the patient in the course of professional treatment but the judge decided that this did not apply to the evidence sought for in the instance before him on the ground that the wife was the

patient and that the confidence, the revelation of which was sought, was not hers but her husband's. In England no privilege attaches so as to protect the medical man in any case but the principle upon which he resists the effort to extort from him in the witness-box the secrets of his patients is no doubt that upon which the American law was originally founded. If we regard the question decided by the judge as a matter of principle we shall see that the point is one not quite easy to determine offhand. The husband, no doubt, spoke in confidence to Dr. McKee and was entitled to have his communication jealously guarded. On the other hand, the wife was the patient and directly she alleged that she had contracted venereal disease and had been corroborated as to this by her medical attendant her honour was impugned unless she could show that her husband and no one else had infected her. Dr. McKee questions the soundness of the judicial decision and observes, probably correctly, that if he had attended the husband for gonorrhœa as well as the wife he could not have been ordered to give evidence on the subject. It may be considered, however, that on the question of principle the medical man is not bound to keep a secret which the person confiding it to him has himself given away, as he is in cases where his confidant has done his best to preserve it. The husband in Dr. McKee's case had told his secret to his wife and had apparently also told her or had allowed her to infer that he had told her medical adviser. In such circumstances he certainly had no right to complain if the medical man obeyed the judge's order without demur.

The Unlawful Detention of a Medical Man.

The Common Serjeant at the recent sessions of the Old Bailey disposed of a case which has been reported on two or three occasions in its earlier stages and which fortunately is of an unusual character. An obstetric assistant, Mr. Shrivell, having been summoned to attend a maternity case at a tenement in Spitalfields, found that the woman was not likely to be delivered immediately and prepared to leave, intending to return later, when he found that the household were not disposed to allow him to do so. Presumably they were afraid that he would not return and that the patient would suffer from his absence. They were aliens—very "undesirable aliens" from the medical man's point of view—and so were not amenable to the persuasion or threats that would have influenced the indigenous poor of the district and they were prepared to use force to bar his exit. The medical man in these circumstances submitted to be locked in, awaited the confinement of his patient, which took place in the course of the night, and when it had been brought to a satisfactory conclusion was allowed to leave. Afterwards, however, he applied, with the support of the hospital authorities, for legal process against his captors. The application was for an offence not often brought before criminal courts and was based upon facts of so unusual a character that Mr. Cluer before whom it was made had some doubt about granting a summons, and when it came on for hearing refused to dispose of the matter summarily. Accordingly the two persons responsible, a man and a woman named Lazarus Linsburg and Fanny Leiss, were indicted at the Old Bailey and pleaded guilty to counts in the indictment alleging imprisonment of the prosecutor. As to this charge the Common Serjeant ruled that imprisonment without a belief in the existence of a lawful cause for it (such as the belief that a felony has been committed) amounts to an assault at law without actual violence taking place. Mr. Bosanquet, however, did not think it necessary to treat the prisoners with severity, for he set them at liberty after binding them over to come up for judgment if called upon. There is a humorous aspect of their practical method of securing the presence of the medical man but at the same time it is to be hoped that the report of the case will have been circulated and read in the newspapers published by the various foreign communities of the East end and that such acts will not be repeated. The experience described has been stated not to be unique and to the gentleman imprisoned it must have been a source of annoyance and trouble. Moreover, if there had been considerable delay or if the case had developed unexpected features demanding communication with the outer world, or still more if through some untoward circumstance it had had a fatal termination, the position of the imprisoned medical attendant might have become a very awkward one.

Public Health and Poor Law.

LOCAL GOVERNMENT BOARD.

REPORTS OF MEDICAL OFFICERS OF HEALTH.

The City of Aberdeen.—It is an interesting fact and one that illustrates in a remarkable fashion the progress of preventive medicine that typhus fever has now become so rare that outbreaks of it are worth recording. Dr. Matthew Hay in his report for the month of December last describes an outbreak of this disease which first came beneath his notice owing to the fact that a labourer who was believed to be suffering from measles and who was sent into hospital in consequence of delirium was found after admission to be suffering from typhus fever and a week later the patient's wife was admitted with similar symptoms. Again, two days after this a case of supposed enteric fever was notified and this on being examined proved to be another case of typhus fever. This patient had about 14 days before he became ill attended upon two friends—a father and a grown-up son—both of whom had died, and it was found that the latter of these two patients had visited a family where there had been several cases of illness and where the father of the family had died in October last. This household had evidently been instrumental in spreading the disease and four of those who had visited this house were already dead. Altogether, up to the date of his report, Dr. Hay had discovered 40 cases and ten deaths. Curiously enough, one of the elementary schools was found to have been operative in spreading the disease among children. As Dr. Hay remarks, the fact that few medical men have seen typhus fever renders the diagnosis of the disease extremely difficult, more especially when, as in this instance, most of the cases occurred in the badly lighted and badly ventilated houses of the poor in circumstances which make it very difficult to determine the presence of the eruption peculiar to typhus fever. Fortunately, the hospital staff do not appear to have become infected and in this sense the disease manifested a marked contrast to its behaviour in the old days of the London Fever Hospital when medical officers, chaplains, and nurses were constantly succumbing to the disease. This outbreak is also instructive as illustrating how very misleading notification, when applied to a but rarely seen disease such as typhus fever, may prove.

The City of London.—Dr. W. Collingridge, in his report for December, 1904, and the first half of January, 1905, draws attention to the momentous subject of the importation of diseased pork from Denmark. It appears that up to the present there has been a sort of informal arrangement between the Danish Government and the City Corporation by means of which the attention of the Danes was called to any case of the condemnation in England of Danish meat. This arrangement was materially facilitated by the practice pursued in Denmark of attaching distinctive labels to meat, and when these labels were returned to Denmark owing to the meat labeled being bad it was easy for the Danes to follow up the matter. It was understood, however, that in such cases steps would be taken to remedy the evil. Unfortunately, although the label system has worked well with respect to beef, it does not appear to have prevented the arrival of pork in a condition unfit for human food, and Dr. Collingridge tells us that during the last three months of 1904 39 pigs were seized, while during the first half of January, 1905, no fewer than 49 were so condemned. It is apparently a common practice in Denmark to remove the thyroid glands and other parts of the carcass, a proceeding which considerably increases the difficulty of detecting diseased meat. Certainly, as the Danish authorities point out to Dr. Collingridge, it might be expected that tuberculosis of pigs would be rare in Denmark seeing that all skim milk has to be boiled in order to prevent the spreading of tuberculosis through this means. But be this as it may, a large number of tuberculous carcasses find their way into this country *viâ* Denmark, so much so, indeed, that Dr. Collingridge suggests the discontinuance of the return of the labels inasmuch as the labels do not now afford a proper guarantee of excellence.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

In 76 of the largest English towns 9001 births and 5220

deaths were registered during the week ending Feb. 11th The annual rate of mortality in these towns, which had been 18·1, 18·4, and 18·0 per 1000 in the three preceding weeks, further declined to 17·4 per 1000 last week. In London the death-rate was 17·6 per 1000, while it averaged 17·4 per 1000 in the 75 other large towns. The lowest death-rates in these towns were 8·1 in Hornsey, 8·5 in Walthamstow, 9·2 in Smethwick, 9·3 in Handsworth (Staffs), 9·7 in East Ham, 10·9 in Croydon, and 11·8 in Leyton; while the highest rates were 24·2 in Hastings and in Rhondda, 24·6 in Norwich, 24·9 in Middlesbrough, 28·2 in Merthyr Tydfil, 29·0 in Hanley, and 29·8 in Stockton-on-Tees. The 5220 deaths in these towns last week included 401 which were referred to the principal infectious diseases, against 358, 376, and 368 in the three preceding weeks; of these 401 deaths, 110 resulted from whooping-cough, 100 from measles, 72 from diphtheria, 47 from diarrhœa, 45 from scarlet fever, 24 from "fever" (principally enteric), and three from small-pox. In Hornsey, Brighton, Wolverhampton, Coventry, Derby, Halifax, York, Swansea, and in ten other smaller towns no death from any of the principal infectious diseases was registered, while they caused the highest death-rates in Southampton, Hanley, Nottingham, Burnley, Stockton-on-Tees, West Hartlepool, Rhondda, and Merthyr Tydfil. The greatest proportional mortality from measles occurred in Leyton, Portsmouth, Southampton, Reading, Nottingham, Stockton-on-Tees, West Hartlepool, Cardiff, and Merthyr Tydfil; from scarlet fever in Northampton and Stockton-on-Tees; from diphtheria in East Ham, Walsall, Birkenhead, Middlesbrough, and Merthyr Tydfil; from whooping-cough in Willesden, West Ham, Hastings, Hanley, St. Helens, South Shields, Rhondda, and Merthyr Tydfil; from "fever" in Devonport; and from diarrhœa in Burnley. Of the three fatal cases of small-pox registered in these towns last week one belonged to Oldham, one to Burnley, and one to Bradford. The number of small-pox patients in the Metropolitan Asylums Hospitals, which had been 18, 15, and 13 at the end of the three preceding weeks, had further declined to nine at the end of last week; one new case was admitted during the week, against one, none, and one in the three preceding weeks. The number of scarlet fever cases remaining under treatment in these hospitals and in the London Fever Hospital on Saturday, Feb. 11th, was 2077, against 2174, 2096, and 2070 at the end of three preceding weeks; 260 new cases were admitted during the week, against 225, 251, and 229 in the three preceding weeks. The deaths in London referred to pneumonia and diseases of the respiratory system, which had been 377, 478, and 444 in the three preceding weeks, further declined to 400 last week, but were 76 in excess of the number in the corresponding period of last year. The causes of 54, or 1·0 per cent., of the deaths in the 76 towns last week were not certified either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in West Ham, Portsmouth, Bristol, Nottingham, Leeds, Newcastle-on-Tyne, and in 47 other smaller towns; the largest proportions of uncertified deaths were registered in Ipswich, Liverpool, Warrington, Blackburn, and South Shields.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in eight of the principal Scotch towns, which had been 20·1, 20·3, and 19·9 per 1000 in the three preceding weeks, further declined to 18·2 per 1000 during the week ending Feb. 11th, but was 0·8 per 1000 in excess of the mean rate during the same period in the 76 large English towns. The rates in the eight Scotch towns ranged from 13·4 in Paisley and 14·7 in Leith to 21·3 in Perth and 22·7 in Aberdeen. The 612 deaths in these towns included 23 which were referred to whooping-cough, nine to diarrhœa, seven to measles, five to "fever," three to diphtheria, and two to scarlet fever. In all, 49 deaths resulted from these principal infectious diseases last week, against 72, 79, and 85 in the three preceding weeks. These 49 deaths were equal to an annual rate of 1·5 per 1000, which was 0·2 per 1000 above the mean rate last week from the same diseases in the 76 large English towns. The fatal cases of whooping-cough, which had been 33, 44, and 46 in the three preceding weeks, declined again last week to 23, of which 17 were registered in Glasgow and three in Edinburgh. The deaths from diarrhœa, which had been 17, nine, and 19 in the three preceding weeks, declined again to nine last week and included four in Glasgow, three in Edinburgh, and two in Leith. The fatal cases of measles, which had been six in each of the two preceding weeks, increased last week to seven, all of which occurred in Glasgow. The deaths from "fever," which had been six and four in the two preceding weeks, rose again to five last week and included four in Glasgow. The fatal cases of diphtheria, which had been nine in each of the two preceding weeks, decreased last week to three, of which two occurred in Glasgow. The deaths referred to diseases of the respiratory organs in these towns, which had been 156, 163, and 146 in the three preceding weeks, further declined last week to 130, but were slightly in excess of the number in the corresponding period of last year. The causes of 19, or more than 3 per cent., of the deaths registered in these eight towns last week were not certified.

HEALTH OF DUBLIN.

The death-rate in Dublin, which had been 21·2, 25·5, and 24·2 per 1000 in the three preceding weeks, rose again to 25·2 per 1000 during the week ending Feb. 11th. During the past four weeks the death-rate has averaged 24·0 per 1000, the rates during the same period being 17·7 in London and 19·6 in Edinburgh. The 183 deaths of persons belonging to Dublin registered during the week under notice were seven in excess of the number in the preceding week and included seven which were referred to the principal infectious diseases, against 10, 18, and nine in the three preceding weeks; of these, three resulted from diarrhœa, two from scarlet fever, and two from "fever," but not any from small-pox, measles, diphtheria, or whooping cough. These seven deaths were equal to an annual rate of 1·0 per 1000, the death-rates last week from the principal infectious diseases being 1·3 in London and 0·8 in Edinburgh. The 183 deaths in Dublin last week included 27 among children under one year of age and 45 among persons aged 60 years and upwards; the deaths both of infants and of elderly persons showed a marked decline from the respective numbers recorded in the preceding week. Nine inquest cases and five deaths from violence were registered; and 60, or nearly one third, of the deaths occurred in public institutions. The causes of four, or more than 2 per cent., of the deaths in Dublin last week were not certified.

VITAL STATISTICS OF LONDON DURING JANUARY, 1905.

In the accompanying table will be found summarised complete statistics relating to sickness and mortality in the City of London and in each of the metropolitan boroughs. With regard to the notified cases of infectious disease it appears that the number of persons reported to be suffering from one or other of the nine diseases specified in the table was equal to an annual rate of 5·8 per 1000 of the population, estimated at 4,684,794 persons in the middle of the year. In the three preceding months the rates had been 9·0, 7·2, and 6·1 per 1000. The rates were considerably below the average in Paddington, Kensington, the City of Westminster, St. Marylebone, Hampstead, Stoke Newington, and the City of London, while they showed the largest excess in Hammersmith, Hackney, Bethnal Green, Stepney, Poplar, Wandsworth, and Woolwich. The prevalence of small-pox showed a marked decline last month; of the four cases of this disease notified during January, two belonged to Woolwich and one each to Shoreditch and Lewisham. The Metropolitan Asylums hospitals contained 15 small-pox patients at the end of last month, against one, three, and 17 at the end of the three preceding months; the weekly admissions averaged one, against none, one, and four in the three preceding months. Scarlet fever was slightly less prevalent last month than in other recent months; among the various metropolitan boroughs this disease showed the highest proportional prevalence in Chelsea, Hackney, Bethnal Green, Wandsworth, and Lewisham. The number of scarlet fever patients under treatment in the Metropolitan Asylums hospitals at the end of the month was 2067, against 2662, 2566, and 2349 at the end of the three preceding months; the weekly admissions averaged 209, against 359, 249, and 233 in the three preceding months. The prevalence of diphtheria during January was in excess of that recorded in the preceding month; this disease was proportionally most prevalent in Hammersmith, Fulham, Hackney, Bethnal Green, Stepney, Poplar, and Woolwich. The Metropolitan Asylums hospitals contained 836 diphtheria patients at the end of last month, against 940, 893, and 800 at the end of the three preceding months; the weekly admissions averaged

ANALYSIS OF SICKNESS AND MORTALITY STATISTICS IN LONDON DURING JANUARY, 1905.

(Specially compiled for THE LANCET.)

CITIES AND BOROUGHS.	Estimated population in the middle of 1905.	NOTIFIED CASES OF INFECTIOUS DISEASE.										DEATHS FROM PRINCIPAL INFECTIOUS DISEASES.										Deaths from all causes.	Death-rate per 1000 living.	Deaths of Infants under one year to 100 births.
		Small-pox.	Scarlet fever.	Diphtheria.*	Typhus fever.	Enteric fever.	Other continued fevers.	Puerperal fever.	Erysipelas.	Cholera.	Total.	Annual rate per 1000 persons living.	Small-pox.	Measles.	Scarlet fever.	Diphtheria.*	Whooping-cough.	Typhus fever.	Enteric fever.	Other continued fevers.	Diarrhœa.	Total.	Annual rate per 1000 persons living.			
LONDON...	4,694,794	4	971	569	—	107	2	23	294	—	2070	0·8	2	167	30	51	100	—	19	—	43	361	1·0	6092	17·0	113
West Districts.																										
Paddington	147,935	—	24	8	—	2	—	1	7	—	42	3·7	—	—	2	—	3	—	—	—	1	6	0·5	179	15·8	122
Kensington	180,083	—	19	13	—	3	—	—	14	—	49	3·5	—	1	—	1	4	—	1	—	2	9	0·7	225	16·3	135
Hammersmith	119,037	—	30	35	—	1	—	3	6	—	75	8·2	—	2	—	3	5	—	—	—	—	10	1·1	127	13·9	83
Fulham	157,210	—	30	25	—	3	—	3	9	—	70	5·8	—	8	2	—	8	—	1	—	2	21	1·7	190	15·8	126
Chelsea	74,496	—	24	3	—	—	—	—	7	—	34	5·9	—	1	1	—	3	—	—	—	—	5	0·9	92	16·1	141
City of Westminster	175,606	—	25	7	—	2	—	—	6	—	40	3·0	—	—	—	—	1	—	—	—	1	2	0·1	231	17·1	110
North Districts.																										
St. Marylebone	129,453	—	10	5	—	2	—	—	19	—	36	3·6	—	—	1	—	3	—	—	—	—	4	0·4	174	17·5	73
Hampstead	88,142	—	7	2	—	1	—	1	3	—	14	2·1	—	—	1	—	1	—	—	—	—	2	0·3	59	8·7	113
St. Pancras	236,183	—	40	28	—	6	—	1	19	—	94	5·2	—	4	2	3	4	—	2	—	2	17	0·9	367	20·3	112
Islington	342,994	—	65	28	—	6	—	1	17	—	117	4·4	—	15	2	1	6	—	—	—	4	28	1·1	457	16·3	105
Stoke Newington	52,828	—	9	3	—	—	—	—	1	—	13	3·2	—	1	2	1	—	—	—	—	—	4	1·0	60	14·8	136
Hackney	228,479	—	58	35	—	11	—	—	25	—	129	7·4	—	11	2	2	2	—	—	—	—	17	1·0	251	14·3	86
Central Districts.																										
Holborn	56,481	—	13	7	—	—	—	—	3	—	23	5·3	—	—	—	1	2	—	1	—	—	4	0·9	107	24·7	130
Finsbury	98,207	—	14	9	—	4	—	—	11	—	38	5·0	—	8	3	—	3	—	2	—	3	19	2·5	175	23·2	131
City of London	22,425	—	1	2	—	—	—	—	2	—	5	2·9	—	—	—	1	—	—	—	—	—	1	0·6	45	26·2	125
East Districts.																										
Shoreditch	116,565	1	21	17	—	3	2	1	11	—	56	6·3	1	8	2	2	5	—	1	—	—	19	2·1	181	20·2	140
Bethnal Green	130,401	—	39	26	—	8	—	—	16	—	89	8·9	—	2	3	4	3	—	—	—	1	13	1·3	219	21·9	145
Stepney	305,466	—	73	95	—	14	—	—	42	—	224	9·6	—	12	2	11	8	—	3	—	6	42	1·8	451	19·3	119
Poplar	170,280	—	32	45	—	5	—	—	18	—	100	7·7	—	10	2	5	3	—	1	—	3	24	1·8	266	20·4	154
South Districts.																										
Southwark	208,523	—	31	22	—	2	—	—	17	—	72	4·5	—	—	1	6	11	—	—	—	2	20	1·3	320	20·0	136
Bermondsey	129,006	—	23	9	—	3	—	1	9	—	45	4·5	—	6	2	1	6	—	2	—	—	17	1·7	212	21·4	99
Lambeth	313,045	—	53	19	—	4	—	1	17	—	94	3·9	—	—	5	—	1	—	—	—	7	13	0·5	369	15·4	103
Battersea	177,532	—	38	13	—	7	—	—	22	—	80	5·9	—	2	1	1	4	—	—	—	2	10	0·7	208	15·3	96
Wandsworth	265,392	—	108	22	—	7	—	3	25	—	163	8·0	—	13	3	4	2	—	2	—	2	26	1·3	279	13·7	96
Camberwell	271,240	—	67	19	—	4	—	3	24	—	117	5·6	—	—	—	—	8	—	—	—	4	12	0·6	336	16·1	114
Deptford	114,496	—	25	8	—	1	—	—	14	—	48	5·5	—	—	—	—	—	—	1	—	1	2	0·2	121	13·8	121
Greenwich	103,493	—	19	9	—	—	—	1	9	—	38	4·8	—	—	—	—	2	—	1	—	—	3	0·4	119	15·0	95
Lewisham	144,420	1	43	12	—	5	—	—	11	—	72	6·5	1	1	—	—	1	—	—	—	—	3	0·3	152	13·7	75
Woolwich	125,372	2	32	43	—	3	—	3	9	—	92	9·6	—	2	—	4	1	—	1	—	—	8	0·8	150	15·6	101
Port of London	—	—	—	—	—	—	—	—	1	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

* Including membranous croup.

115, against 139, 123, and 99 in the three preceding months. The prevalence of enteric fever showed a considerable decline last month; among the various metropolitan boroughs the greatest proportional prevalence of this disease occurred in Hackney, Finsbury, Shoreditch, Bethnal Green, Stepney, and Battersea. The number of enteric fever patients in the Metropolitan Asylums hospitals, which had been 225, 178, and 237 at the end of the three preceding months, had declined again to 134 at the end of last month; the weekly admissions averaged 17, against 25, 25, and 22 in the three preceding months. Erysipelas was proportionally most prevalent in St. Marylebone, Hackney, Bethnal Green, Stepney, Battersea, and Deptford. The 23 cases of puerperal fever notified during the month included three in Hammersmith, three in Fulham, three in Wandsworth, three in Camberwell, and three in Woolwich.

The mortality statistics in the table relate to the deaths of persons actually belonging to the various metropolitan boroughs, the deaths occurring in public institutions having been distributed among the several boroughs in which the deceased persons had previously resided. During the four weeks ending Jan. 28th, the deaths of 6092 persons belonging to London were registered, equal to an annual rate of 17·0 per 1000; in the three preceding months the rates had been 14·3, 14·6, and 18·4 per 1000. The lowest death-rates in London last month were 8·7 in Hampstead, 13·7 in Wandsworth and in Lewisham, 13·8 in Deptford, 13·9 in Hammersmith, and 14·3 in Hackney; the highest rates were 20·3 in St. Pancras, 20·4 in Poplar, 21·4 in Bermondsey, 21·9 in Bethnal Green, 23·2 in Finsbury, 24·7 in Holborn, and 26·2 in the City of London. The 6092 deaths from all causes included 361 which were referred to the principal infectious diseases; of these, two resulted from small-pox, 107 from measles, 39 from scarlet fever, 51 from diphtheria, 100 from whooping-cough, 19 from enteric fever, and 43 from diarrhœa. The lowest death-rates from these diseases occurred in Paddington, the City of Westminster, St. Marylebone, Hampstead, Lambeth, Deptford, Greenwich, and Lewisham; and the highest rates in Fulham, Finsbury, Shoreditch, Stepney, Poplar, and Bermondsey. Of the two deaths from small-pox one belonged to Shoreditch and one to Lewisham. The 107 fatal cases of measles were 96 below the average in the corresponding periods of the ten preceding years; this disease was proportionally most fatal in Fulham, Hackney, Finsbury, Shoreditch, Poplar, Bermondsey, and Wandsworth. The 39 deaths from scarlet fever showed a decline of 13 from the corrected average number; among the various metropolitan boroughs this disease showed the highest proportional mortality in Stoke Newington, Finsbury, Shoreditch, Bethnal Green, Bermondsey, and Lambeth. The fatal cases of diphtheria numbered 51 last month, against an average of 147 in the corresponding period of the ten preceding years; the highest death-rates from this disease occurred in Hammersmith, Bethnal Green, Stepney, Poplar, Southwark, and Woolwich. The 100 deaths from whooping-cough were 74 below the corrected average number; among the various metropolitan boroughs this disease was proportionally most fatal in Hammersmith, Fulham, Chelsea, Shoreditch, Southwark, and Bermondsey. The 19 fatal cases of "fever" showed a decline of 31 from the average number in the corresponding periods of the ten preceding years; the highest "fever" death-rates occurred in St. Pancras, Holborn, Finsbury, Shoreditch, Stepney, and Bermondsey. The 43 deaths from diarrhœa were slightly below the average; among the various metropolitan boroughs this disease was proportionally most fatal in Finsbury, Stepney, Poplar, Lambeth, and Camberwell. In conclusion, it may be stated that the aggregate mortality in London last month from the principal infectious diseases was nearly 48 per cent. below the average.

Infant mortality, measured by the proportion of deaths among children under one year of age to registered births, was equal to 113 per 1000. The lowest rates of infant mortality were recorded in Hammersmith, St. Marylebone, Hackney, Bermondsey, Battersea, Wandsworth, Greenwich, and Lewisham; and the highest rates in Chelsea, Stoke Newington, Shoreditch, Bethnal Green, Poplar, and Southwark.

THE SERVICES.

ROYAL NAVY MEDICAL SERVICE.

THE following appointments are notified:—Fleet Surgeon A. E. Weightman to the *Spartiate*. Staff Surgeons: H. P. Jones to the *Hermes*, on commissioning; P. K. Nix to the *Blake*; A. W. B. Livesay to R.M. Depôt, Deal; and H. W. G. Green to the *Dido*, on recommissioning. Surgeons: A. J. Hewitt to R.M.A. Barracks, Eastney; P. F. Alderson to Plymouth Hospital; F. M. V. Smith to the *Dido*, on recommissioning; and G. D. Walsh to the *Scylla* for the *Halcyon*, on commissioning. Surgeon J. Brunt is placed on the Emergency List, with seniority of Oct. 1st, 1879.

Deputy Inspector-General of Hospitals and Fleets Gerard James Irvine has been promoted to the rank of Inspector-General of Hospitals and Fleets in His Majesty's Fleet. Fleet Surgeon Arthur William May has been promoted to the rank of Deputy Inspector-General of Hospitals and Fleets in His Majesty's Fleet (dated Feb. 7th, 1905).

The undermentioned Surgeons have been promoted to the rank of Staff Surgeon in His Majesty's Fleet:—Alexander George William Bowen and George Ley (dated Nov. 11th, 1899); Robert Dundonald Jameson (dated May 16th, 1902); William Bernera Macleod, Harry Spicer, and John Alexander Lanford Campbell (dated Nov. 14th, 1902); Herbert Henry Pearse and Charles James Edward Cock (dated May 15th, 1903); John William Craig (dated May 13th, 1904); and Edwyn Robert Grazebrook (dated Nov. 10th, 1904).

ROYAL ARMY MEDICAL CORPS.

Lieutenant-Colonel J. G. Harwood is appointed to the Southern District on the retirement of Lieutenant-Colonel P. J. Dempsey. Captain P. J. Bodington is posted to the Home District for duty on arrival home from Ceylon. Captain H. H. Norman has left Woolwich. Lieutenant S. M. Adye-Curran is placed on temporary half-pay on account of ill-health.

Lieutenant-Colonel G. D. Hunter, D.S.O., is seconded for service with the Egyptian Army (dated Feb. 2nd, 1905).

The undermentioned Captains to be Majors (dated Jan. 30th, 1905):—C. T. Samman, H. A. Berryman, C. G. Spencer, C. E. P. Fowler, T. H. J. C. Goodwin, D.S.O., A. E. C. Keble, D. J. Collins, and J. B. Anderson. Captain R. E. G. Phillips, from the Seconded List, to be Captain (dated Feb. 1st, 1905). Lieutenant R. G. Anderson, from the Seconded List, to be Lieutenant (dated Jan. 30th, 1905).

VOLUNTEER CORPS.

Royal Garrison Artillery (Volunteers): 1st East Riding of Yorkshire: Surgeon-Lieutenant-Colonel W. Draper is granted the honorary rank of Surgeon-Colonel (dated Feb. 11th, 1905).

Rifle: 4th Volunteer Battalion the Devonshire Regiment: Surgeon-Major J. R. Thomas (Brigade-Surgeon-Lieutenant-Colonel, Senior Medical Officer, Devon Volunteer Infantry Brigade) to be Surgeon-Lieutenant Colonel (dated Feb. 10th, 1905). Surgeon-Lieutenant-Colonel J. R. Thomas (Brigade-Surgeon-Lieutenant-Colonel, Senior Medical Officer, Devon Volunteer Infantry Brigade) is granted the honorary rank of Surgeon-Colonel (dated Feb. 11th, 1905). 2nd Volunteer Battalion the East Surrey Regiment: Surgeon-Lieutenant-Colonel W. Gandy (Brigade-Surgeon-Lieutenant-Colonel, Senior Medical Officer, East Surrey Volunteer Infantry Brigade) is granted the honorary rank of Surgeon-Colonel (dated Feb. 11th, 1905). 1st Volunteer Battalion the Essex Regiment: Surgeon-Lieutenant J. Aitken to be Surgeon-Captain (dated Feb. 11th, 1905). 13th Middlesex (Queen's Westminster): Surgeon-Captain W. Rose resigns his commission (dated Feb. 11th, 1905).

ROYAL ARMY MEDICAL CORPS (VOLUNTEERS).

The London Companies: Lieutenant H. S. Collier resigns his commission (dated Feb. 11th, 1905).

DEATHS IN THE SERVICES.

Surgeon-Major-General Thomas Walsh, A.M.S. (retired), on Feb. 7th, at his residence, Mer Vue, Booterstown, county Dublin. He entered the service as an assistant surgeon in 1858, became surgeon in March, 1873, and surgeon-major a month later, brigade-surgeon in 1884, surgeon-colonel in 1889, and surgeon-major-general in 1894. He was employed with the Jowaki Afridi expedition of 1877-78 and in the Afghan war in 1879-80. As senior medical officer in the latter expedition he did some good work, for which he was mentioned in despatches. In the Egyptian war of 1882 he was sanitary officer to the 1st Division and was present at the engagement at Tel-el-Mahuta, at the action at Kassassin, and at the battle of Tel-el-Kebir.

THE WAR IN THE FAR EAST.

The sufferings of the troops at the front from the extreme cold have been indescribable but the weather has recently become much warmer. According to the latest accounts from Manchuria the thermometer during the day registered only three degrees of frost. There is considerable difficulty in ascertaining what is the exact truth about the supplies of the Russian forces in the field; the accounts are conflicting, but it may be safely concluded that the position of the large Russian army in Manchuria, dependent on the Trans-Siberian railway only, must be a precarious one. Nor is this the only subject on which the accounts are so conflicting as to be irreconcileable with one another. Those regarding the state of Port Arthur at the end of the siege, and especially as to the number of sick and wounded in hospital at that time as now given by General Stoessel, are quite at variance with the statements previously made by others. There have been no military movements of importance on the part of the belligerent forces during the week. The rumours of peace continue but whether they have any foundation beyond the fact that everybody would be glad to hear that an end had come at last to the terrible loss of life and suffering is more than anyone can say. Both sides have suffered heavily by the war but the losses on the part of the Russians in men, money, and *matériel*, and still more perhaps in prestige, have been simply enormous. It is a consideration of the whole history of the war and of her present situation that makes it so difficult for the Russian Government to approach the Japanese with any proffered terms of peace at the present time.

The Kwangschan correspondent of the *Novoe Vremya* quotes statistics of the Manchurian army sanitary bureau relating to infectious diseases, showing that the sanitary state of the army was remarkably satisfactory on Jan. 21st. There were only 156 cases of dysentery, 752 cases of "abdominal typhus," 32 of "eruptive typhus," 15 of "recurrent typhus," and 3 of typhus not classified, 198 of influenza, 1 of epidemic gastritis, 35 of intermittent fever, 44 of Siberian plague, 51 of erysipelas, 3 of scurvy, 4 of small-pox, 1 of measles, and, finally, 205 of diarrhœa. The whole army is supplied with warm clothing. The nourishment is without question good and even at the outposts hot food is served twice daily. The only bad point is the difficulty in furnishing the army with fuel. The chief representative of the special Red Cross Committee, A. J. Gutchkoff, telegraphs from the Far East that on making a round of the positions the medical men of the detachment dealing with infection have declared that in view of the excellent sanitary condition of the army an "anti-contagion" detachment is required only in Kharbin where there are 35,000 hospital beds. In the spring two flying detachments will probably proceed to the south.

A report from Kharbin of Jan. 5th states that there are few invalids in the hospitals of the Red Cross Society. There is no epidemic disease in the town. The hospital of the society is comfortably installed in the best communal building in Kharbin. The confidence and activity of the staff insure perfect order.

Correspondence.

"Audi alteram partem."

MEDICAL TEACHING IN THE METROPOLIS.

To the Editors of THE LANCET.

SIRS,—Your leading article on the above subject published in THE LANCET of Feb. 11th prompts me to call attention to the fact that one branch of medical teaching in our London medical schools stands in sad need of stimulation. All will agree that clinical surgery is well taught in the London schools, but the like cannot, I fear, be said of clinical medicine. In spite of the learning and skill of our London physicians few of them, alas, are experts in the art of imparting that knowledge and that skill, for, unhappily, the possession of knowledge and the ability to impart it are not one and the same thing, and of no branch of knowledge is this more true than of clinical medicine.

How are we to account for this dearth of good clinical teachers? It is mainly owing to the fact that in the election of physicians to teaching hospitals due regard is not had to their teaching capabilities. This is as mistaken in policy as it is wrong in principle. The ability to teach is a more necessary qualification in the member of the staff of a teaching hospital than a brilliant academic career. On him devolves, as member of the staff, a double duty—not only the exercising of his craft but the teaching others how to exercise that craft, and in proportion as he succeeds in these must his election be deemed to have been a wise one. To suppose that his teaching duties are merely accessory to his duty as physician is to form an altogether wrong conception of his position. He is under a grave obligation not only to do his best by his patients but also by his pupils—to arm them with the means by which they may do successful battle against disease—and thus extend the benefits he confers on humanity far beyond the narrow confines of his hospital.

Under the present system of election it is impossible to be certain of securing the best clinical teachers, inasmuch as little or no opportunity is afforded the young physician prior to his election of demonstrating his teaching capabilities, and once elected he remains on the staff till age, death, or inclination (seldom vouchsafed) removes him from the scene, mounting up the ladder of promotion on the very simple, but most pernicious, principle of seniority. No concern run on these lines—commercial, medical, or any other—can achieve its full measure of success. In each and all and always every facility should be given for the right men to come to the front. "Catch your capable men," as Huxley tersely puts it, should be a guiding principle in every department of human activity. The system of permanent election not only exposes the schools to the danger of being saddled with inefficients, but makes no provision against men "going off" prematurely, for it is a strange and unhappy fact that just as some women lose their beauty after the first flush of youth so some men who start with every apparent prospect of brilliant success somehow or other soon begin to lag behind and finally drop out of the ranks of serious competition: they cease to develop, enthusiasm and initiative wane, the plastic cerebral protoplasm hardens all too soon, and the brilliant forceful man of yesterday becomes the stolid, uninspired platitudinous individual of to-day. He has failed to realise the expectations formed of him and is no longer fit for the position he holds. We are all sorry for him, but our sympathy for him must be tempered by our sense of duty to others and not blind us to the fact that he is no longer the right man in the right place, and that by allowing him to continue in it we are doing a grievous wrong to others, to many others—I mean the students, and thus through them to a large section of the community.

How can we best meet these difficulties? Obviously by a system of provisional election. Assistant physicians should be elected for a certain term and on a distinct understanding that if at the end of that term they have failed to realise expectations they will not be re-elected. Their ability as teachers can be gauged with mathematical precision—i.e., by the following they get among the students. A careful daily record should be made of the number of students attending the out-patient and in-patient departments of every member of the hospital staff, and these records should be given prominent publicity every three months. This plan would not only enable an estimate of individual teaching capacity to be formed, but tend to promote a healthy rivalry in clinical teaching, stimulating every member of the staff to perfect himself as a teacher and compelling him to realise that clinical teaching is not only a great and noble but likewise a very difficult art, one in which efficiency can be attained only after long and painstaking cultivation.

You, Sirs, give expression in your article to the belief "that in the near future every hospital will be found able to supply numerous junior appointments for those who desire occupation and opportunity of demonstrating their powers of teaching." A consummation devoutly to be wished, and to the furtherance of which I would suggest the advisability of appointing to each of the larger hospitals two or more posts of sub-assistant physician, tenable, say, for one year, and affording the holders ample facility for demonstrating selected patients to students. I believe it would also be a good plan for the great schools to throw open their doors to clinical teachers from other hospitals than their own. There are not a few capable men in London connected with non-teaching hospitals. Could not some arrangement be come to by which their services might be utilised in the schools? A

further plan of improving the teaching of clinical medicine in London would be to do away with systematic lectures on medicine and to give in their stead systematic demonstrations of selected patients. The kind of information it is sought to convey in lecture can be much better taught in tutorial class.

Finally, I would make it obligatory for every candidate for a post on the permanent medical staff of a teaching hospital to have spent one year in special study (as clinical clerk or otherwise) at each of the special departments for diseases of the eye, skin, and the nose and throat; two years at a special hospital for children's diseases, and another two years at a special hospital for diseases of the nervous system. At any cost the great hospitals must exclude the medical exclusivist. By such means as these I believe that much might be done to improve the teaching of clinical medicine in London and to raise it to a position worthy of the world's great metropolis.

I am, Sirs, yours faithfully,

Wimpole-street, W., Feb. 12th, 1905. HARRY CAMPBELL.

THE BUILDING BY-LAWS.

To the Editors of THE LANCET.

SIRS,—In the reference you have been good enough to make in your leading article on the above subject in your issue of Feb. 11th, p. 369, to my letter in the *Times* you suggest that the difficulty to which I drew attention as to the incongruity of the terms "urban" and "rural" in their application to sanitary districts and the need for the remedy I proposed of discontinuing this distinction of districts and applying it to the houses themselves are to some extent met by the greater latitude which the Local Government Board now allows to district councils in regard to the adoption of either urban or rural by-laws to portions only of their districts. But I think you will see upon consideration that the remedy is a very imperfect one because it entails the necessity of defining the boundaries of the portions of the district to which the urban or rural powers shall apply, always a serious difficulty, and one which would perpetually require revision in growing districts in order to meet altering requirements.

My proposal of dealing with a house as urban or rural, according to the width of its curtilage, gets over this difficulty altogether. At present all building by-laws, I believe, prescribe that a certain space shall be kept uncovered in front of, and behind, the premises to be erected. My proposal would involve a similar restriction on each side of the premises if they were to be erected under rural by-laws, and in that case would leave the builder a considerable amount of latitude as to the construction of his house, so long as he complied with certain indispensable requirements as to drainage, water-supply, disposal of dry refuse, dryness of foundations and walls, &c. But if he were unable to satisfy the minimum condition of circumjacent space and, of course, if he proposed to erect two or more dwellings in actual contact with one another, then he would come under the more rigid control of urban by-laws. The provision is one that would obviously work automatically. There would be no necessity for any Local Government Board inquiry, no definition of boundaries would be required. Whether the site of the proposed house were in a large city or in the midst of a wood the sole question would be, What is the size of your curtilage? And it is clear that it would have to be large enough to allow the whole of the refuse of the probable occupants of the house to be dealt with on their own premises, if necessary, and in such a way as not to create a nuisance to their neighbours.

It would not be necessary, as you seem to think, that a house erected under rural by-laws should remain always detached. But if its owner wished to build another in connexion with it or within the prescribed distance he would only be able to do so on condition that he brought his old house up to the urban standard in all conditions. If it were originally substantially built this would not probably involve serious outlay, but if it were of the bungalow type or jerry-built, though apparently substantial, he would probably find it cheaper to pull it down altogether. The only person who would have to provide against the contingency you cite of a road originally bordered by rural villas which becomes gradually converted into streets of continuous bricks and mortar would be the individual who might originally erect the suburban villas or those who might purchase them from him. Each would have to look ahead and consider how far his future interests might be affected by his adopting a style of building which might involve serious outlay in adapting the houses to urban conditions wherever the march of urbanisation should make such a change advantageous. My proposal, therefore, is not to do away with building by-laws but to differentiate them into two categories, as at present, which shall be automatically applicable to any house according to the amount of land by which it is to be surrounded.

I am, Sirs, yours faithfully,

Gloucester. FRANCIS T. BOND, M.D. Lond.

DUODENAL ULCER.

To the Editors of THE LANCET.

SIRS,—There are one or two points in Mr. B. G. A. Moynihan's interesting paper on Duodenal Ulcer in THE LANCET of Feb. 11th, p. 340, on which one would be glad to have further information. He speaks in his present paper as well as in the one which you published in December, 1901, of the mimicry of appendicitis, which is referred to by various authors. What one would like to know is whether he has observed it himself in cases of perforation. Personally I have not except in one case which I did not see until some time after it occurred. I fancy this statement depends on the fact that before attention had been called to the frequency of duodenal perforation the necessity for early operation was overlooked; but now that such cases, largely owing to Mr. Moynihan's writings, are earlier recognised and more promptly treated the diagnosis has become easier and the mimicry of appendicitis is consequently rare.

When an attack of sudden and violent abdominal pain associated with collapse is accompanied, say, two or three hours later by lack of movement of the right rectus above the umbilicus, coupled with localised pain and tenderness referred to the same spot, a ruptured gastric or duodenal ulcer is certainly to be inferred, and if the rupture be in the stomach and not in the duodenum it will not be more than about one inch from the pylorus. At least that is my experience, and this symptom is due, I fancy, not so much to the "colon hillock" as to the attachment of the mesentery which largely influences the direction that the effused contents follow. No mention is made of flushing in order to rid the abdomen of the intestinal contents in this present paper. It would be interesting to know if Mr. Moynihan still advocates it. I have long since discarded it in all ruptured gastric and duodenal ulcers and I am sure my results have been better since.

I am, Sirs, yours faithfully,

Harley-street, W., Feb. 13th, 1905. W. BRUCE CLARKE.

PULMONARY TUBERCULOSIS AND ITS ASSOCIATIONS.

To the Editors of THE LANCET.

SIRS,—The interesting annotation upon tuberculosis in Nottinghamshire calls surprised attention to pulmonary tuberculosis being more fatal in rural than in urban districts. In THE LANCET of April 15th, 1899, p. 1005, and in the museum catalogue of the British Congress on Tuberculosis the greater fatality of phthisis in the country compared to towns is pointed out. It was a feature of the disease up to middle life and was to be observed as a general rule all over England 1881–90. I desire to draw attention to the value of even slight analysis in proclaiming the lines of incidence of this disease, so necessary a precursor of useful prophylaxis. The city of Nottingham report for the same year (1903) affords a good example.

Tuberculosis Mortality per 1000 living at Ages over 15 years.

Men, occupied	2·408	Women, occupied...	0·881
,, unoccupied	1·377	,, unoccupied	1·5

The public cannot be expected to read a multitude of figures, but if they get a high value from an analysis such as urban and rural it is evidently much higher when carried on to the distinctions in age and sex as above. Every medical officer will take the social, economic, or hygienic classification he finds best. My excuse for troubling your columns is

the great want of classifications to guide us in the direction most promising for the prevention of tuberculosis.

I am, Sirs, yours faithfully,

Feb. 13th, 1905. HUGH R. BEEVOR.

FORMOLYPTOL IN DIPHTHERIA.

To the Editors of THE LANCET.

SIRS,—About two months ago a note was published in THE LANCET on the successful use of mulyptol locally for diphtheria and a week or so after that I was called to see a child, aged 11 years, whom I found complaining of her throat, which her mother said had been sore for 12 hours. She had a temperature of 104·4° F. and both tonsils and the back of the fauces were covered with a thick ashy-grey membrane. I had already sent a child from the family above (it was a tenement house) into the South Devon Hospital for tracheotomy with what proved laryngeal diphtheria and I was told that another child had died in the house from "acute bronchitis." I endeavoured to get some mulyptol but could only get formolyptol, which I used as a spray and also a gargle, besides administering two-minim doses internally. The temperature subsided in 24 hours, the throat cleared up rapidly, and the child was out of all danger in less than two days. Dr. W. L. Fethybridge, pathologist to the hospital, kindly made a culture from a swab and found the diphtheria bacillus. I was most agreeably surprised at the efficacious and rapid way in which the formolyptol acted and hope this note may be useful to those who may have to treat a similar condition.

I am, Sirs, yours faithfully,

C. E. RUSSEL RENDLE,

Feb. 11th, 1905. Assistant Surgeon, South Devon Hospital.

COFFEE AND SEWAGE.

To the Editors of THE LANCET.

SIRS,—Your editorial remarks on the recent decision of Mr. Chapman in the case of the coffee salvaged from the s.s. *Caravellas* are evidently made upon the basis of a very imperfect report of the evidence and are, therefore, I venture to think, a little unfair. I feel sure that I can appeal to your well-known justice to all parties for a hearing so that the facts may be better understood than they have been.

At the hearing of the case I produced evidence and specimens to show: 1. That coffee during roasting attains a temperature of about 180° C., or 356° F., which is maintained for a long time. 2. That before reaching this it remains for a considerable time at or near 100°-103° C. (212°-218° F.), during which time much vapour of water is given off. 3. That after a period of rest or even slight fall of temperature this again advances; various oils and acid products, together with water from the breakdown of the berry by heat, are given off and the berry swells and softens. Its loss in weight is from 15 to 20 per cent. on the dry coffee. 4. The sanitary officials admitted that organisms, pathogenic or not, would not survive this heat coupled with the vapours present. 5. Carefully made cultivations were made from the coffee received from the roasters in the roasted state and no growth of any kind ensued. The roasted berries were quite sterile. It was suggested that toxins produced by the organisms might be present but no evidence of their existence was before the court and I need not enlarge on the improbability of their presence in the roasted coffee.

I also venture to deprecate the use of the term "sewage soaked." I am informed that the ship was sunk between Coalhouse Point and Cliffe, some two miles below Gravesend. The water is no doubt contaminated but it is not fair to call it "sewage." If every bag of sugar, chest of currants, bag of wheat, &c., that got well wetted by such water were condemned there would be enough for the sanitary officers to do. But such things, it is well known, are not stopped, though sugar at least, which is used as often as not without cooking, is far more dangerous than green coffee. It was the fact that it had heated and showed signs of mould that caused the seizure. The sewage suggestion appeared to be an afterthought.

Pray understand that my remarks apply only to the particular lot of 60 tons with which I dealt. I saw no specimens of that condemned elsewhere and express no opinion on their state. It is obvious that green coffee wetted with perfectly good water would ferment and rot in time.

I am, Sirs, yours faithfully,

Feb. 11th, 1905. R. J. FRISWELL.

*** Mr. Friswell is, of course, entitled to his opinion but we may remind him that pollution is not necessarily of a bacteriological kind. The water of the river at the points mentioned is in his own words "no doubt contaminated," whether it be fair or not to call it sewage, and the coffee had been admittedly soaked in this water. No one, we imagine, would relish the idea of drinking water polluted with sewage effluent even if sterile.—ED. L.

CURRENT THEORIES OF THE HEREDITARY PROCESS.

To the Editors of THE LANCET.

SIRS,—In the annotation on the above subject in THE LANCET of Feb. 4th, p. 307, the following statement occurs:—

> Both these writers [Boveri and Delage] have shown that denucleated eggs produced by mechanical extrusion of nuclei can be fertilised in the sea urchin and that they give rise to normal blastulæ, gastrulæ, and larvæ. Hence the "determinants" of heredity are present in the cell body of the egg.

Surely this is a false conclusion, since no notice is taken of the nucleus of the spermatozoon. The fact that if fertilisation is effected by alien spermatozoa the resulting larvæ show purely paternal characters is a very strong argument in favour of Weismann's view that the nucleus is the vehicle of hereditary transmission. There is no evidence in these experiments that the cytoplasm of the ovum plays any part at all in the transmission of hereditary characters.

I am, Sirs, yours faithfully,

CHARLES POWELL WHITE.

St. Thomas's Hospital, Feb. 7th, 1905.

*** From the experiments referred to two entirely opposite conclusions are drawn—viz., that attributed to Professor W. F. R. Weldon, F.R.S., in our issue of Feb. 4th, and that to which Mr. Powell White alludes above. These interpretations are still the subject of discussion. Boveri himself admits that the "merogonie" experiments are equivocal because bastard larvæ, arising by the union of an entire egg with the spermatozoon of a distinct species, may also present the pure paternal form. At the same time, referring to the criticism raised by Pfeffer and others that the spermatozoon is an entire cell and not merely a nucleus, he points out that this argument is not admissible in appraising the part played by the egg protoplasm in fertilisation. In bastard larvæ which have obtained nuclear substance only from the spermatozoon in the fertilisation of egg fragments without nucleus ("merogonie") the paternal type appears exclusively (*vide* Boveri: "Ergebnisse ueber die Konstitution des Zellkerns," Jena, 1904, pp. 104, 105).—ED. L.

COUGH DUE TO INTESTINAL WORM.

To the Editors of THE LANCET.

SIRS,—The extraordinary case of reflex lumbrical irritation contributed to THE LANCET of Jan. 28th by Mr. Prosper St. Leger Liston reminds me of a somewhat similar pathological picture painted by the father of one of my patients in the first half of the last century. There is one striking difference however; for the main figure in the sketch, by Dr. R. J. Graves of Dublin, to which I allude, was a Tænia instead of an Ascaris lumbricoides, otherwise the title of Mr. Liston's case would have served for that of Dr. Graves. The latter physician was not as fortunate as the former; he did *not* make out *his* case but suffered the humiliation of being "scored off" by an unqualified lady doctor.

Dr. Graves's case was one of "severe cough and loss of weight due to tapeworm in the intestine." The details are much too instructive to be lost. A young woman attacked with symptoms of violent and alarming "bronchitis" was attended by a friend of Dr. Graves. When seen by the latter he found that the fits of coughing went on for hours with extraordinary intensity. The cough was dry, noisy,

hollow, and incessant, repeated every five or six seconds during sleep at night as well as during the day. The violence was such that it threatened to "tear her chest in pieces." Her friends wondered how any frame could withstand so constant and terrible an agitation. Yet there was no fever, the chest exhibited nothing but the ordinary râles of what was in those days called "dry bronchitis," and the loss of flesh was by no means commensurate with the apparent gravity of the condition. This unfortunate girl was bled, leeched, blistered, and antimonialised without the slightest relief. She then had antispasmodics galore but with no effect. Next every species of narcotic was administered without the very faintest benefit. Then, fortunately, her physicians discontinued their visits and the case was taken up by an old retainer in the family. This old woman suggested a full dose of turpentine with castor oil for the relief of colic. *In two or three hours a large mass of tapeworm was passed and every symptom disappeared.* Robert J. Graves was the soul of sincerity. How few men would have had the courage to narrate such a failure as occurring in their own practice. What a lesson in frankness and humility! In treating any cough how needful it is to remember that we can cough from irritation of any portion of the body supplied by the great vago-sympathetic; and what part of the body is not supplied by this most important group of nerves?

How many ceruminous coughs have been treated without an examination of the auditory meatus? At p. 32 of my small work on Eczema I have described a persistent dermatitis of the navel in a child which resisted months of treatment and was then suddenly cured by santonin given to expel a round worm.

I am, Sirs, yours faithfully,
EDWARD BLAKE, M.D. Aberd., &c.

Seymour-street, W., Jan. 28th, 1905.

MOSQUITOES AND MALARIAL FEVER.

To the Editors of THE LANCET.

SIRS,—Not seeing the subject mentioned in THE LANCET I forward to you an extract from the *Times* of Feb. 8th which is not without general interest. It is from "our own correspondent," Colombo, and is as follows:—"Sir H. A. Blake, Governor of Ceylon, announced at a meeting of the Asiatic Society that Sinhalese books of the sixth century described 67 varieties of mosquitoes and 424 kinds of malarial fever caused by mosquitoes."

Putting aside the question of numbers the association of these insects in causation in days long gone past is a matter which seems worthy of notice in present medical literature and the record of it may lead some of those who may have the opportunity to dip more into the subject as detailed in these old books.—I am, Sirs, yours faithfully,

FRANCIS H. WELCH, F.R.C.S. Eng.

Lee, S.E., Feb. 15th, 1905.

MANCHESTER.

(FROM OUR OWN CORRESPONDENT.)

Ancoats Hospital.

A CASE of death from blood poisoning occurred at the Ancoats Hospital on Jan. 18th and at the inquest some strictures were passed on the system in vogue for treating slight cases of accident. A young married mill-hand on Dec. 23rd scratched her hand in the mill. Next day she had pain and was taken to the hospital where she was attended to by a nurse and told to come next morning. However, she eventually died with all the symptoms of general blood poisoning on Jan. 18th. The resident house physician, Dr. F. G. Hack, said it was the custom for the nurses to treat trivial cases of accident without consulting the medical officer. The two medical men present could not deal with all the cases. They had 100 beds upstairs to look after. A verdict of "Accidental death" was returned. The jury did not attach blame to anyone but expressed the opinion that every accident should be seen by a qualified medical man. Dr. Hack promised to convey the recommendation to the governing body. In this case the pain in the arm and other symptoms might have led a medical man to take a more serious view of the matter than that taken by the nurse and the confidence of the public generally would no doubt be lowered if it came to be understood that accidents apparently slight but susceptible of fatal developments would probably be seen by a nurse only.

Degrees in Dentistry.

At a meeting of the court of the University of Manchester held on Jan. 18th Professor W. Stirling, in accordance with the recommendation of the board of faculty, moved the adoption of proposed ordinances for degrees and diplomas in dentistry. The Manchester Dental School was founded in 1885 and there are now about 40 students. These students pass the same matriculation as others and before they obtain a licence to practise have to study for four years. Special attention has to be given to dental anatomy and physiology, human and comparative. They go through the same attendance on surgery and pathology as required for the medical students and must have a year's attendance at a general hospital for clinical surgery. The student has to learn the mechanical part of his art at a dental hospital. It was proposed to institute degrees in dentistry of Bachelor of Dental Surgery and Master of Dental Surgery. In this Manchester is not alone, Trinity College, Dublin, and the University of Birmingham already giving dental degrees while Liverpool proposes to do so. The motion, which was seconded by Dr. J. Dreschfeld, was carried and it was resolved that the adoption of the ordinances should be communicated to the Universities of Liverpool and Leeds and to the General Medical Council.

Manchester Royal Infirmary.

The annual meeting of the trustees of the Manchester Royal Infirmary was held on Feb. 10th. Mr. Cobbett, the chairman of the board of management, gave some interesting information as to the progress being made towards the erection of the new infirmary at Stanley-grove. The ground was cleared, sewerage and drainage work had been executed, so that now the surface was ready for the commencement of the laying of the foundations. There is still some anxiety among a section of the supporters of the infirmary as to the central receiving house. It was decided some time since that there should be no beds but the fear seems to be that so much may be expended at Stanley-grove that there may be no funds available for the receiving house even without beds. The chairman was able, however, to remove that impression. Two gentlemen resigned the membership of the board because they could not share in the financial responsibility for the scheme which they consider too costly. One of them, moreover, gave as an additional reason a supposed change in the character of the institution, that "it will become much more a teaching hospital instead of the primary one for the treatment of the sick poor." (The construction here seems to present some difficulty.) "Placed there the professional influence will increase and the lay share in the management must decrease," a state of things to which he objects. It seems a curious idea, and one that could only occur to a layman, that there is any antagonism between the treatment of a patient where it is carried out under the quick, intelligent eyes of students of medicine and that given where there are none to observe and none to criticise—the only difference at all likely to occur being, perhaps, that in the former case it will be more thorough and more carefully carried out than in the latter. If this change is objected to the strong man would retain his post in order that he could oppose the change and not retire on the mere rumour that such a change may be impending. Manchester is a great medical centre and the teaching and education of the next generation of practitioners is surely as important a work in relation to the welfare of the people as any that can occupy the best energies of the wisest and most benevolent among us. There is plenty of room for the coöperation of lay and professional helpers. For many years past they have worked cordially together, to the great advantage of the community, and there is no reason to fear that their relations will be less useful and agreeable in the future.

The Hospital for Skin Diseases.

The new hospital in Quay-street, adjoining the old one, is approaching completion and it is expected that the whole scheme may be completed next year. An appeal for funds has brought in nearly £31,000 but £5000 more are required. Of the 57,159 attendances during the year 22,665 were made by "light" patients. Dr. R. B. Wild said the results of the special "light" treatment were highly satisfactory. The x rays, the Finsen, and the Finsen-Reyn lamps had been chiefly used. Radium had not fulfilled the high expectations of a year ago but this was thought to be "largely due to the fact that the amount of radium available was sufficient to treat only such small areas of disease that they could be treated more effectively by other methods."

Early Marriages in Burnley.

Burnley is, as you are aware, one of the Lancashire towns notorious for its high infantile death-rate. In 1903 it was at the rate of 269 per 1000. One of the ministers of the town has very usefully occupied one Sunday in the month with a series of addresses on "Burnley Black Spots" and he recently spoke on the infantile death-rate and its causes. Speaking generally, he attributed it to "drink, bad housing, early marriages, and the factory system, under which large numbers of married women in the very early morning take out their children to be nursed by women who had also their neighbours' children to look after and whose one idea was to make the babies sleep." The one point specially brought out is the unusual prevalence of early marriage as compared with some of the other Lancashire towns. Oldham has 20 persons married under 18 years of age, while Burnley has 38, and 73 under 19 years of age as against 111 at Burnley. Bolton and Blackburn have 31 and 26 respectively married under 18 years of age. The figures apply in the main to the factory or mill workers and when we consider the poor, and in many cases the miserably poor, physique of this class in the manufacturing towns, as illustrated among other things by the high percentage of rejections of would-be recruits and remember that so many of them, boys and girls, marry before attaining to the full height of their puny development, it is not to be wondered at that their children are feeble and degenerate and little able to withstand the adverse influences surrounding them from the moment they draw their first breath. Nor is it to be wondered at that this widespread enfeeblement of a large proportion of the population should cause anxiety and foreboding for the future.

The Midwives Act.

The Manchester corporation, in view of the fact that the Midwives Act will come into operation on April 1st, has taken steps for the carrying out of the obligations to be imposed on it. In August last it appointed a special committee—the midwives supervising committee—which was to receive the delegated powers of the council as the local supervising authority. It consists of 12 members of the council and four co-opted members, Dr. Arnold W. W. Lea, Dr. Ernest Annacker, Mr. F. C. Scotson, and Dr. Margaret S. Bell. The first duty of the committee was to appoint a qualified medical practitioner to act under the supervision of the medical officer of health as the "executive officer" under the Act. There were 40 applicants for the post, which carries a salary of £250, and they included six lady doctors. The committee recommended the appointment of Dr. Margaret Merry Smith. She will be required to devote the whole of her time to the work, to visit midwives "both systematically and irregularly," and to see that their homes are in a sanitary condition, to examine their cases or bags of instruments, to ascertain that their case-books are properly kept, and that they understand the use of antiseptics, and also that they are "suitably provided in washable dresses." She will also be required to visit the cases attended by the midwives to satisfy herself that the requisite procedures are carried out, that there is strict cleanliness in all things, and that "suitable provision is made for the dieting both of mother and child." In cases of great poverty is the corporation going to feed the mother and child or will that be left to the guardians? She will also take charge of the notifications of deaths and stillbirths and report to the local authority any case of negligence, malpractice or misconduct. The local authority may, after investigation, report to the Central Board. The local authority may, if it should seem necessary, suspend a midwife to prevent the spread of infection. The lady appointed will have to lead a "strenuous life."

Feb. 14th.

LEEDS.

(FROM OUR OWN CORRESPONDENT.)

The Court Dinner of the University of Leeds.

UNDER the chairmanship of the Pro-Chancellor, Mr. A. G. Lupton, the first Court dinner of the University was held on Feb. 6th. The guests numbered about 110 and included the Lord Mayor of Leeds, the Vice Chancellor, Sir Francis Powell, Mr. Rowland Barran, M.P., and many representatives of local authorities and of educational bodies. It was well attended by the professorial staff and by other members of the teaching body. The toast of "The University" was proposed by Mr. Alfred Moseley, C.M.G., who was the guest of the evening. He gave his experiences in Germany and in the United States and his speech was a strong claim for due recognition being given by all who have the welfare of the empire at heart to the necessity of a sound scientific, technical, and business training of university standard being accessible to all who were likely to be able to profit by it. In his reply the Pro-Chancellor stated that the assets of the University were worth £300,000 and that there were upwards of 800 day students and 300 evening students. He acknowledged the generosity of the Clothworkers Company and expressed the hope that the imagination of wealthy men might be fired and that the University might benefit by their contributions. The Mayor of Bradford in an eloquent speech appealed to the authorities of the University to develop the highest ideals of a university in arts, science, law, and medicine, and Sir Francis Powell spoke in favour of the old classical studies.

The Finance of the General Infirmary.

Under the will of the late Mr. Christopher Charles Weatherill of Leeds this institution will receive a very welcome and handsome addition to its funds. Mr. Weatherill, who died in 1902, directed that his household furniture, plate, books, &c., should be given to his sister and directed his trustees to pay her an annuity of £300 for life. His real estate and the residue of his personal estate was given to his trustees upon trust to accumulate the whole of the income of the estate at compound interest until the death of his sister when the principal and accumulations were to be handed to the treasurer of the Leeds General Infirmary. That lady died on Feb. 10th and when the death and legacy duties are paid the sum at the disposal of the infirmary will be something between £116,000 and £117,000. The conditions stipulated for by the testator are as follows—viz., that a ward be founded and sufficiently equipped and endowed in the infirmary for accident cases, to be called the "Weatherill Accident Ward"; that a white marble monument of the testator with a suitable inscription be erected in the ward, and that the treasurer of the infirmary cause a copy of the will to be placed once every year in a conspicuous position so that everyone entering the infirmary may see it. Subject to these conditions the surplus is to be applied to the general surgical purposes of the infirmary. The financial condition of the infirmary has for some years been matter of increasing anxiety to the board of management. Three years ago the treasurer had to announce that the annual expenditure exceeded the income by some thousands of pounds, and it was felt that unless an increase of income could be secured the work of the greatest of the Leeds charities would have to be curtailed. As the result of a very special effort initiated and energetically carried on by the treasurer, Mr. Charles Lupton, the annual expenses have been met and the work has not had to be curtailed. The expenditure for 1903 was £32,700, as against £30,500 for 1902, while for 1904 the expenditure cannot fall short of £34,000. This expenditure is bound to increase if the high standard of work of the infirmary is to be maintained. The maintenance of the new Arthington Hospital at Cookridge, which is really a part of the infirmary and under the management of the board, will involve an additional expenditure of £2000 per annum. For some years it has been felt by the staff that the institution of a properly equipped clinical laboratory is essential, and the board are giving this, as it always does the suggestions of the staff, its careful consideration.

The Leeds Association for the Prevention and Cure of Tuberculosis.

This association has issued its fifth annual report. For some time after the institution of the association the work was experimentally carried on near Otley, in Wharfedale, some ten miles from Leeds. The next step was the fitting up of Gateforth Hall as a sanatorium. Gateforth Hall is the property of the Leeds corporation, is situated near Selby, and is let at a reasonable rent to the association. The accommodation here has now been raised and 30 patients can be treated. There are extensive grounds and gardens on the estate and in many respects the place is well adapted for the purposes of a sanatorium. The number

of patients treated during 1904 was 101 and the average number of days spent by each patient in the sanatorium was 101¼. The results of treatment have been distinctly encouraging. At the central offices of the association in Leeds applicants for admission are examined by the honorary officers. The number of applicants has been uniformly much in excess of the accommodation at Gateforth and naturally the cases most suitable for sanatorium treatment have been selected. In this way the necessity of instituting a home or hospital for the more acute class of cases or for cases in which it was doubtful whether sanatorium treatment would be successful became apparent, and this year the society is able to announce that it has secured Armley House and has fitted it up as a hospital which will accommodate 27 patients of this class and which is admirably adapted for the purpose.

Holidays for Poor Children.

Following the example of other centres Leeds has started a poor childrens' holiday camp. The first annual report dealt with the work at Hest Bank, Morecambe. Though the work was not begun till July 130 boys and 130 girls had been kept for various times in the camp. The health of the children had been good. The cost per child of from eight to 14 years of age had been 5*s*. 3*d*. per week—3*s*. 11*d*. for food and 1*s*. 4*d*. for railway fare. The diet had been generous and in many cases the children had gained six pounds in weight. For the next five years the camp is to be held at Silverdale, the rent of the site having been generously promised by Mr. and Mrs. Arthur Briggs, who during Mr. Briggs's mayoralty did so much for the initiation of the scheme. One of the buildings of the Bradford exhibition has been purchased and erected at a total cost of £374 and it is hoped that the forthcoming season may be started with a few pounds in hand.

Feb. 14th.

IRELAND.

(FROM OUR OWN CORRESPONDENTS.)

The Irish Medical Association and the Local Government Board.

THE opening stage of the appeal by the Irish Medical Association against the action of the Local Government Board in abolishing a dispensary district in the county of Louth was reported in THE LANCET of Feb. 4th, p. 328. The Lord Chancellor has since delivered the judgment of the Court of Appeal, dismissing with costs the appeal of the Irish Medical Association and upholding the action of the Local Government Board.

Royal College of Surgeons in Ireland.

It is publicly announced that owing to the illness of His Excellency the Lord Lieutenant the conferring of the Honorary Fellowship of the Royal College of Surgeons in Ireland on the Provost of Trinity College and the College dinner for which invitations were issued for Feb. 11th have been postponed until further notice.

Dublin Sanitary Association.

At a meeting of the Dublin Sanitary Association held on Feb. 9th a letter from the secretary of the public health committee of the corporation was read stating that the by-laws to regulate street trading by children in Dublin, under the provisions of the Employment of Children Act, 1903, as approved by His Excellency the Lord Lieutenant, are being printed and that badges are being prepared to be worn by the children licensed to trade in the streets of the city.

British Medical Association.

The annual meeting of the Leinster (formerly Dublin) branch of the British Medical Association will be held on Saturday, Feb. 25th, at 4.30 P.M., in the hall of the Royal College of Physicians, Kildare-street, when Sir Thomas Myles, president-elect, will deliver the address. The annual dinner of the branch will take place in the College hall at 7.30 P.M. on the same day.

Honour for Sir Francis Cruise.

Sir Francis R. Cruise, M.D. Dub., D.L., Honorary Physician-in-Ordinary to His Majesty in Ireland, has received a brief from the Pope appointing him a Knight of the Order of St. Gregory the Great, together with the star or decoration of that order.

Dispensary Medical Officers' Salaries.

A special committee of the Coleraine guardians having conferred with the medical officers of the union as to the scale of salaries recommends the following plan to be adopted. That the minimum salary of each dispensary medical officer in the union, as well as that of the workhouse medical officer, be £100 a year, increasing by £10 every five years to a maximum of £150. A statement of the medical officer points out that a penny in the £1 in all Ireland amounts to £62,000 and that the salaries of all the dispensary medical officers amount to £88,000, half of which is recouped by the Government. An average ratepayer of £24 valuation pays a little over 1*s*. to the dispensary medical officers, so a halfpenny in the £1 added would give all that the medical officers ask. The matter is to be considered at a future special meeting of the board.

The Public Bodies Order.

The Local Government Board has issued an Order for the guidance of public bodies in Ireland which is being strongly and adversely criticised on the grounds that it increases clerical work and expense of maintenance without effecting any improvements which might compensate for these disadvantages. For instance, in reference to asylums this Order prescribes new forms relating to the audit of asylum accounts which will necessitate more officials and will interfere with the smooth and economical working of such institutions. The duty of the Local Government Board is clearly to see that local bodies transact their business honestly and that they fulfil the law but it is absurd to make vexatious regulations which serve no good object but increase the expense of local bodies. At the ordinary meeting of the Belfast asylum committee on Feb. 13th a motion was unanimously carried protesting against the adoption of such an Order on the ground among others that it contains provisions which exceed the statutory powers of the Local Government Board. Other local bodies in Ireland are taking similar action.

A Health Lecture for the People.

A lecture fully illustrated by limelight views was delivered in the Exhibition Hall, Belfast, on Feb. 14th, by Dr. Henry O'Neill, editor of the *Belfast Health Journal*, on the Health of Belfast. A collection was made in aid of the Belfast Royal Victoria Hospital.

Feb. 14th.

PARIS.

(FROM OUR OWN CORRESPONDENT.)

Brewer's Yeast in the Treatment of Typhoid Fever.

AT a meeting of the Medico-Chirurgical Society held on Jan. 23rd M. Hirtzmann gave details of three severe cases of typhoid fever occurring in adults. The symptoms included dryness of the tongue, diarrhœa, and other conditions usually found in typhoid fever; the temperature rose to, and remained at, 40° C. (104° F.) for some time. In addition to small amounts of sulphate of quinine he gave to all three patients 60 grammes (two ounces) of brewer's yeast daily in three doses. This treatment was commenced about the seventh day of the illness. After the taking of the yeast the temperature fell to 38° C., not subsequently rising above 39°; the gastro-intestinal symptoms improved, the tongue was no longer dry and coated, the diarrhœa disappeared, and the pyrexial stage terminated about the twenty-first day. M. Hirtzmann believed that the yeast acted as an antiseptic. He employed either Karcher's or Grueber's fresh yeast, the latter being preferable as it was almost liquid. In those cases the typhoid fever was unquestionably water-borne, for the well supplying the house of one of the patients had been evidently contaminated by fæcal matter from a house which stood at a higher level and in which there had been some time previously a case of typhoid fever.

Respiratory Exercises and Re-education in the Treatment of Convalescents.

At a recent meeting of the Société Médicale des Hôpitaux M. Siredey and M. Rosenthal contributed a paper on Respiratory Exercises and Re-education in the Treatment of Convalescents. They said that respiratory insufficiency was one of the causes of the general debility which showed itself after an acute illness. It was easily recognised by the

following symptoms which the patient presented—namely, nasal insufficiency, shown by inability to breathe 20 times through both nostrils; thoracic insufficiency, shown by absence or impairment of the movements of the thorax; and diaphragmatic insufficiency, shown by immobility or recession of the abdomen during inspiration, a condition met with in pseudo-pleurisy of the bases of the lungs. Respiratory re-education under medical supervision was, in their opinion, the specific treatment for respiratory insufficiency. In the case of convalescents it constantly produced a progressive threefold effect—namely, expansion of the thorax, diuresis, and increase of weight. It promoted in a marked degree the recuperation of the vital functions which followed acute illnesses and the general health of the patients improved rapidly. It ought to be combined with other forms of treatment and the action of the latter was enhanced by it. Although of great power it did not require for its application any special institution or any special apparatus. The system could be practised anywhere, either in a hospital or in the poorest dwelling. It needed nothing more on the part of the patient than the absence of any mechanical obstacle to the passage of air through the rhino-pharyngeal tract, and nothing more on the part of the medical man than a willing mind and a qualification which was indispensable though too much neglected—namely, a knowledge of the fundamental laws of human physiology.

Poisonous Cream Cakes.

M. Metchnikoff, the deputy director of the Pasteur Institute, has just been taking part in an interesting inquiry. For some months past he has been receiving almost daily samples of cream cakes from the same batch as those which had given rise to symptoms of poisoning in those persons who had eaten them. M. Girard of the Municipal Laboratory had also investigated the cakes. The Society of Confectioners and Bakers was aware of these researches and its members, when they knew that results had been obtained, convened a meeting at which Dr. Metchnikoff gave an interesting discourse. The cause of all the mischief, he said, was the white of the egg which contained microbes. It is not clear why the white of certain eggs contains microbes but the fact is certain that some hens do lay eggs the whites of which contain microbes. Even freshly laid eggs when cultivated in a cultivator give cultures. This being so the method in which the cream is prepared for the cakes is eminently calculated to develop the microbes. The white of egg slightly warmed is sprinkled with a "cream" which itself is at a temperature of 80° C., one far too low to have any destructive effect on the germs. This "cream" being made of gelatin, sugar, and milk offers an ideal culture medium when the mixture is warmed. This explains why white of egg, even when it does contain germs, gives rise to no symptom of poisoning when it is consumed in the ordinary way without the admixture of "cream." The following method is suggested to avoid future risks. Before sprinkling the white of egg with the "cream" it should be coagulated in boiling sugar which will certainly destroy the germs.

Feb. 14th.

NEW YORK.

(FROM OUR OWN CORRESPONDENT.)

The Prevention of Yellow Fever in Cuba.

THE American Public Health Association met in Havana on Jan. 10th and the principal feature of the introductory proceedings was the address of the President, Dr. Carlos Finlay, chief of the Cuban Health Department. He highly eulogised the labours of American experts to whom, he said, was due the banishment of yellow fever from Cuba. The American Commission, under the leadership of the late Major Reed, had decisively established the true etiology of yellow fever. Dr. Finlay also praised the work of Major Gorgas, chief health officer under General Wood, who, adopting the findings of the commission, succeeded within seven months in ridding Havana of the inveterate enemy. Regarding the two cases of yellow fever which occurred in Santiago Province, Dr. Finlay said it was presumed that they were transmitted by mosquitoes from a quarantined ship. There can be no doubt that the American medical men did a great work in ridding Cuba of yellow fever and are entitled to all the praise bestowed upon them by Dr. Finlay. It would, however, seem from recent reports that since the Cubans themselves have taken over the government of the island sanitary affairs therein have decidedly retrograded. It is therefore needful that the American Government, for the sake of the inhabitants of Cuba, as well as in the interests of the American people at large, should strongly advise, and if necessary bring pressure to bear on, the Cuban authorities in order that the sanitary conditions of Cuba should not be allowed to lapse into their former unsatisfactory state through neglect.

Alleged Swindle by Physicians.

Two physicians were arrested in New York recently charged with engineering a radium cure swindle. The case against them was brought by the New York County Medical Society through its attorney, Mr. Champe S. Andrews. The complainant, a carpenter, stated that the physicians had obtained from him $10,000 (£2000), the amount of his savings of years. The carpenter had been informed by the medical examiners of an insurance company that he had a slight tendency to Bright's disease and went to the defendants for treatment. He was told by them that he was suffering from Bright's disease in its worst form and that his only chance of recovery lay in his being treated by means of radium. He was further told that owing to the great cost of radium the treatment would be very expensive. Acting upon his fears the defendants managed to extort from the plaintiff the sum above mentioned. The New York County Medical Society's agents heard of the matter and initiated an investigation, with the result that some of the so-called radium was obtained and subjected to a searching analysis when it was found that the composition contained no trace whatever of radium, but, as a matter of fact, consisted of gentian, iron, and a few simple drugs ordinarily used in a tonic preparation.

The Adulteration of Whisky

Dr. H. W. Wiley, chief of the United States Bureau of Chemistry, has recently stated that he believes at least 85 per cent. of the whisky sold over the bars in the United States is not "straight" whisky. He states that it is a compound, made of neutral spirit, or alcohol, artificially coloured, often flavoured with artificial essences and sometimes mixed with more or less "straight" whisky to give flavour. The remarks of Dr. Wiley on the adulteration of food and whisky have given rise to much heart-searching and the liquor dealers have been endeavouring to minimise as far as possible the effect of his statements. There can be no doubt, however, that adulteration is conducted on a wholesale scale in the United States and it is not unlikely that the Federal and States Governments may take cognisance of the matter and endeavour to check the evil by means of legislation.

Tuberculosis and Alcohol.

A controversy has been going on in the lay press of New York with regard to the effect of alcohol upon consumptives. Dr. Wiley has recently "stirred a hornet's nest" by making public his opinion that alcohol is beneficial in consumption as well as in certain other diseases. Dr. Knopf, the well-known New York authority on tuberculosis, has stoutly combated these views and declares that in any stage or form of pulmonary tuberculosis large quantities of alcohol are contra-indicated. These views are in direct opposition to those held by Dr. Arthur C. Latham who, writing on the subject in the *Practitioner* for January, declares that when solid food cannot be taken by consumptives alcohol is our sheet anchor and in another part of the same article says that "nothing but good results from the administration of large quantities of alcohol when fever is present so long as the pulse is becoming slower, the appetite better, the skin and tongue moister, and the patient quieter." Opinions diverge greatly as to the position of alcohol as a nutritive agent. In America probably the medical profession is almost equally divided on the question.

Feb. 6th.

NOTES FROM INDIA.

(FROM OUR SPECIAL CORRESPONDENT.)

A Case of "Sati" in Behar.

THE desire for the barbaric custom of "Sati" seems to still linger in the Hindu mind. A recent case in Behar was attended by an enormous and sympathising crowd and the

village watchman refused to lay information with the police. A Brahmin died and the body was laid on the pyre. The widow, having bathed in the small river close by and adorned herself as for her marriage, took her seat on the pyre and called on her son to do his duty as a devout Hindu. The son with other Brahmins placed lighted chips of wood previously soaked in ghee under the pyre. As the flames reached the widow she is said to have writhed about but finally to have stood up, then turned towards the setting sun and immediately fell back, apparently overcome by the rapidly increasing flames. During this time the crowd were shouting their incantations, there were beating of drums and clanging of cymbals, and probably little or nothing was heard of any cries from the terrible pyre. Fortunately the son and his accomplices have had severe punishment administered to them and this horrible offence is not likely to be repeated.

Lady Ampthill Nurses' Institute.

This nursing institute was started in Madras last July but the staff of nurses has only recently been completed. Two of the nurses have come out from England, the others having been trained in India. Good work has already been done and the want of a trained nurse so long felt in Madras has to a great extent been remedied. This want is greatly experienced in nearly all parts of India except in the cities of Calcutta and Bombay and the establishment of other institutes and nursing associations is under consideration.

The Increasing Plague Mortality.

The mortality from plague throughout India is rapidly increasing. Last week there were 25,719 deaths, as compared with 24,385 for the previous seven days and 22,645 recorded for the last week of the past year. The United Provinces returned 11,777 deaths, the Punjab 5569, Bengal 3318, the Bombay districts 2886, the Central Provinces 444, Hyderabad State 399, Rajputana 352, Madras Province 341, Bombay city 192, and Calcutta 33. Since these figures were published plague has broken out in a fishing village on the outskirts of Madras city. The village has been burnt and the patients and "contacts" have been segregated. Dead rats discovered have been found to be swarming with plague bacilli. The Mauritius emigration depôt adjoining with about 500 emigrants has been declared plague-infected and a special quarantine depôt has been established. Another village has been found infected but no further cases have occurred amongst those isolated. This looks as if Madras city, which has escaped so long, will at last be stricken with the disease. The recrudescence in Bombay City and Calcutta is developing and the former is also suffering from a severe outbreak of small-pox. During the past week the whole of Northern India has experienced severe cold and as the greatest mortality is now occurring in those parts we shall be able to see if the course of the disease is in any way modified.

Jan. 28th.

Medical News.

TRINITY COLLEGE, DUBLIN.—At examinations held in Hilary term the following candidates were successful:—

FINAL EXAMINATION.

Section A.—Gustav W. Thompson, William Hutchinson, Richard A. Connell, Malcolm K. Acheson, Archibald L. Robinson, Theodore C. Somerville, Charles G. Sherlock, Henry D. Woodroffe, Wilfred L. Hogan, Langford V. Hunt, Herbert J. Wright, and Francis O'B. Kennedy.

FOREIGN UNIVERSITY INTELLIGENCE.—*Berlin:* Dr. Karl Kaiserling, *privat-docent* of Pathological Anatomy, and Dr. Heinrich Wolpert, *privat-docent* of Hygiene, have been granted the title of Professor.—*Munich:* Dr. Robert Gaupp has been recognised as *privat-docent* of Psychiatry.—*Naples:* Dr. Ugo Benenati and Dr. Giovanni Castronuovo have been recognised as *privat-docenten* of Internal Pathology.—*Prague (German University):* Dr. Eduard Pietrzikowski, *privat-docent* of Surgery, and Dr. Rudolf Fischl and Dr. Raudnitz, *privat-docenten* of Pædiatry, have all been granted the title of Professor.—*Vienna:* Dr. Wilhelm Schlesinger has been recognised as *privat-docent* of Internal Medicine.

THE LONDON, ABERDEEN, BANFF, AND KINCARDINE ASSOCIATION.—The annual dinner of this association was held on Feb. 10th at the Criterion Restaurant, London. Sir Dyce Duckworth in proposing the principal toast, that of "Scotland," had some rather critical remarks to make upon young Scotland. Allowing that Scotchmen were famous all the world over for *perfervidum ingenium*, he thought it a question whether the *ingenium* was so perfervid as in former times. The facilities of communication had become so numerous, luxury had grown to such an extent, and there was so much Carnegie-spoon-feeding north of the Tweed that doubts had arisen as to whether the earnestness and assiduity of the rising generation in Scotland were as intense as formerly. Only a few days ago an old undergraduate of the University of Edinburgh told him how he had found in the union of the university students playing whist in one room and billiards being played in another at 3 o'clock in the afternoon in the middle of the winter session. As an old student of the university he of course remembered billiards and whist being played there and he had no objection to whist and billiards in their proper place, but he doubted the advisability of students playing cards and billiards at 3 o'clock in the afternoon and he hoped that such trivialities would not be permitted to interfere with the work of Scotch students of the present day. He urged students to assume the earnestness and to cultivate the industry which their forefathers possessed. Sir Patrick Manson responded to the toast with a humorous speech. Surgeon-Colonel J. Richardson, in replying to the toast of "The Imperial Forces," proposed by Mr. J. W. Barclay, said that the navy was now so formidable that the mere mention of it got on the nerves of some of our neighbours; in regard to the army it was being forged and when finished it would be a powerful thunderbolt. Amongst those present were Mr. J. Cantlie, Dr. A. M. R. Sinclair, Dr. G. B. Currie, Dr. J. Mitchell Bruce, Dr. T. I. Rowell, and Mr. G. Tocher.

RESTRICTIONS ON THE SALE OF PATENT MEDICINES IN VENEZUELA.—The British Foreign Office has received a copy of a decree published in the Venezuelan official gazette of Dec. 15th, 1904, on the subject of the sale of patent medicines. It declares that the sale of patent or secret medicines which are not authorised by the Medical Council, even though approved by foreign faculties, is now prohibited in Venezuela. The decree accordingly provides for the establishment of a commisssion to undertake the examination and classification of such medicines. Manufacturers of foreign patent medicines must submit the products which they wish to import into Venezuela to this commission within four months from the date of publication of the decree. The application must be in the customary legal form and must state the name of the article, the principal ingredient, and the dose to be taken, and should be accompanied by two samples of the article with the same information on the label. Each application—one for each product submitted—will be subject to a fee of 20 bolivars (15*s.* 10*d.*) and the power of attorney must bear a 5-bolivar stamp. Four months from the date of the publication of the decree unauthorised patent medicines will be classified by the Customs in the fifth class of the tariff for a period of two months, during which time they may still be submitted to the commission; this term expired, they will be included in the list of articles prohibited to be imported. Secret or patent medicines subsequently compounded, however, will be examined and classified by the commission in accordance with the regulations.

SALE OF A MEDICAL PRACTICE.—At the Devon Assizes on Feb. 6th and 7th Mr. Ellis Pearson of Bideford sought to recover from Dr. A. Lane damages for fraud in connexion with the sale of the goodwill of a practice at Bideford. The defendant denied fraud and counterclaimed for fees which, he alleged, the plaintiff had received on his behalf. The plaintiff, who employed no solicitor or accountant in connexion with the purchase, admitted that he had received certain of the fees and gave credit for them. Evidence showed that Mr. Pearson purchased from Dr. Lane for £1000 a practice stated to be worth £800 per annum. The practice, however, according to Mr. Pearson, was only worth about £185 a year. After hearing a considerable amount of evidence Mr. Justice Lawrence in summing up said that the only question for the jury to decide was whether there was a substantial practice carried on by the defendant or whether the practice was built up simply and solely for making a good appearance on a rotten foundation for the purpose of selling it. The jury found that the practice was built up for sale and assessed the damages at £200. It was stated that the plaintiff had paid £57 into court, a sum realised by the collection of

outstanding debts, and judgment was given for Mr. Pearson for £143.

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH.—A quarterly meeting of the Royal College of Physicians of Edinburgh was held on Feb. 7th, Dr. J. Playfair (the President) being in the chair. Dr. Alexander Goodall was introduced and took his seat as a Fellow of the College. Mr. David Duncan Main, M.R.C.P. Edin., L.R.C.S. Edin., Shanghai, China, was admitted by ballot to the Fellowship of the College. Mr. Patrick Hehir, L.R.C.P. Edin., F.R.C.S. Edin., Manipur, Assam, was admitted by ballot to the Membership of the College after examination. The registrar reported that since the last quarterly meeting 44 persons had obtained the Licence of the College by examination.

THE STUDENTS' UNION, ST. BARTHOLOMEW'S HOSPITAL.—The committee of the Students' Union of St. Bartholomew's Hospital has decided to hold annually one or more smoking concerts to promote the social intercourse amongst all St. Bartholomew's men. The proceeds will go to the funds of the union. The second smoking concert will be held on Monday, Feb. 27th, in the Grand Hall of the Criterion, at 8.15 P.M. Mr. Anthony Bowlby, F.R.C.S., C.M.G., will be in the chair. Tickets, price 1*s.* 6*d.* each, can be obtained from the secretaries at the hospital, Mr. W. G. Loughborough and Mr. H. J. Gauvain.

CENTRAL MIDWIVES BOARD.—The members of the Central Midwives Board met on Feb. 9th at 6, Suffolk-street, Pall Mall, W., Dr. F. H. Champneys being in the chair. The report of the standing committee concerning the applications for recognition as teachers of midwifery and the applications for approval of certain institutions as training schools for midwives was submitted to the Board. Mr. E. Parker Young expressed his opinion that applications for approval as training schools should not be postponed from meeting to meeting but that the Board should come to some conclusion in regard to each case. Before the report of the standing committee was formally received by the Board and adopted Sir William J. Sinclair delivered his judgment on the Board and its methods in the following terms:—"As a ground for declining to discuss in detail the applications before the Board I desire to state my opinion that the Board has recognised such unsatisfactory applicants as teachers of midwifery and has approved such unsuitable institutions as midwifery training schools that I do not see on what principle I can now object to any applicant for recognition as a teacher or to any institution as a training school. I can only look forward to the Board continuing its present policy so that an unanswerable case will soon be made out for reconstitution of the Board by an amendment of the Act." The Board decided that Poor-law institutions before being approved as training schools for midwives should be subjected to investigation and report and on the suggestion of Sir William Sinclair directed that when considering any application from a workhouse infirmary to be recognised as a training school for midwives a report should be asked for from the chief medical officer and the local supervising authority concerned should be requested to inspect and to report to the Central Midwives Board on the institution.

TWENTY-THIRD ANNIVERSARY DINNER OF THE WEST LONDON MEDICO-CHIRURGICAL SOCIETY.—The members and friends of the West London Medico-Chirurgical Society held the twenty-third anniversary dinner on Feb. 8th at the Wharncliffe Rooms, Hotel Great Central, the chair being occupied by the President of the society, Mr. C. M. Tuke. The President having duly proposed the toasts of "The King" and "The Queen and other Members of the Royal Family," called upon Mr. Alban H. G. Doran to propose the toast of "The Imperial Forces." Mr. Doran in a well-informed speech referred in detail to the changes in the navy which could only result in efficiency. This toast was replied to by the Director-General of the Medical Department of the Royal Navy who made a special reference to the new system to be followed in the naval manœuvres. He commented on the number of famous medical men who had served in the navy, mentioning the names of Professor Huxley and Sir Spencer Wells. Lieutenant-Colonel E. M. Wilson, R.A.M.C., speaking for the sister service, described how keen the men of the Army Medical Service were in the prosecution of their work. The Royal Army Medical Corps was picking out good men in medicine, surgery, and special branches of work and giving opportunities for study and practice. He observed that many of the officers of the Royal Army Medical Corps when they took their study leave came to the West London Hospital where they derived great benefit. The toast of "The Kindred Societies and Guests" was proposed by Dr. Seymour Taylor and responded to by Sir William S. Church and Mr. J. Langton. The toast of "The Society and its President" was proposed by Dr. G. H. Savage who complimented those present on the large number at the dinner, amounting to over 120. After the President had made a suitable reply conversation became general and the company separated at a late hour. Great praise was accorded to Dr. A. Elliot, the senior secretary of the society, for his efforts which resulted in securing a record attendance at the dinner.

DINNER TO SIR ISAMBARD OWEN.—On Saturday last, Feb. 11th, a highly successful and pleasant dinner was given at the Imperial Restaurant, Regent-street, W., to Sir Isambard Owen, principal of the Durham College of Science, by a large number of his friends, colleagues, and late pupils at St. George's Hospital. Before his appointment as principal at Durham Sir Isambard Owen was for 23 years upon the medical staff of St. George's Hospital, and during a large part of that time he filled, and filled with energy and devotion, the delicate post of dean of the school. During the dinner opportunity was taken to present the guest of the evening with a silver tea service as a wedding gift, Sir Isambard Owen's impending marriage having been announced.

UNIVERSITY OF CAMBRIDGE.—The Special Board for Medicine has added to the list of recognised provincial hospitals at which study for the degrees of M.B. and B.C. may be pursued the United Hospitals Clinical School of Liverpool.—The third examination (Part II.) for medical and surgical degrees will begin on May 2nd. The names of candidates should be sent to the registrar by April 17th.—The graces for the establishment of the Huddersfield Lectureship in special pathology passed the Senate on Feb. 16th. The appointment will be made this term.—Sir M. Foster has been appointed an elector to the chair of Physiology and Professor W. F. R. Weldon an elector to the chair of Zoology and Comparative Anatomy.—Dr. D. MacAlister, president of the General Medical Council, having resigned the office of secretary to the Special Board for Medicine, which he has occupied for over 20 years, Dr. Laurence Humphry has been appointed secretary in his place.

PHYSICAL VOICE TRAINING.—A meeting in furtherance of the objects of the Physical Voice Training Society was held at the Medical Society's Rooms, Chandos-street, Cavendish-square, London, W., on Feb. 1st. The Bishop of Bristol presided. The following resolutions passed at the meeting of the society held at Oxford last August were read:—

That the subject of voice training being of such vital importance for public speakers great attention should be paid to it in education, especially at the public schools and universities, in accordance with the memorial on voice training of the British Medical Association.

(The memorial referred to was issued from the offices of the association on Nov. 18th, 1893, and was the outcome of a suggestion of the section of laryngology at the annual meeting of the association held at Nottingham in the previous year.) The second resolution passed at Oxford was as follows:—

That the Physical Voice Training Society founded by the originators of the "Memorial on Voice Training" issued by the British Medical Association on Nov. 18th, 1893, is deserving of further support from the medical profession in general and the laryngologists in particular.

The Chairman said that the object of their meeting was to consider what steps should be taken to give effect to those resolutions. He was strongly of the opinion that there was great need of careful attention to the best methods of voice-producing not only for the clergy but for all engaged in public speaking; he considered that the services in churches could be improved by a proper course of voice training being undergone by those who conduct them; further, that the usefulness in after life of many educated in the universities and colleges was in some measure lost through their not being effective on the platform. In conclusion, he put forward a motion for appointing a committee consisting of clergymen, medical men, and others engaged in educational work to consider and to report upon the means of giving practical effect to the Oxford resolutions.—Dr. W. Jobson Horne, in response to the chairman, also spoke in favour of the motion. He considered that the large

number of conflicting methods of voice training was in itself sufficient reason for investigating the matter with a view of putting it on a practical footing; personally he did not advocate or support any one particular method, doubtless there was some good in each and all. The main point with which they were concerned was how they were to arrive at a satisfactory method and what machinery they were to use to give practical effect to it. It was now some years since the society was founded and the desirability of reconstituting it would doubtlessly receive the attention of the committee which they were about to appoint; he was quite prepared to accept the statement that as many voices had been ruined as had been made by voice training and that made the responsibility of such a society. Dr. V. H. Wyatt Wingrave also spoke in support of the motion which being put to the meeting was unanimously agreed to and a small provisional committee was appointed.

DONATIONS AND BEQUESTS.—Under the will of Mr. C. C. Smith of Wolverhampton £1000 are left to the Wolverhampton and District Hospital for Women.—By the death of Mrs. Mary A. Whitfield the sum of more than £100,000 reverts to the Leeds General Infirmary under the will of the late Mr. C. C. Wetherill of Leeds.—By the will of Mr. James Holmes Lucking of Streatham-hill, Surrey, £2000 each have been left to the Asylum for Idiots at Earlswood, the National Society for Employing Epileptics, the British Home and Hospital for Incurables at Streatham, St. George's Hospital, King's College Hospital, the London Hospital, St. Mary's Hospital, the Middlesex Hospital, the Hospital for Consumption at Brompton, the Royal Hospital for Incurables at Putney-heath, and the National Hospital for the Paralysed and Epileptic; £1000 each to Charing Cross Hospital, Guy's Hospital, the Metropolitan Hospital, the London Free Hospital, the Seamen's Hospital Society, the Westminster Hospital, University College Hospital, the East London Hospital at Shadwell, the City of London Hospital for Diseases of the Chest, the Evelina Hospital for Sick Children, the Hospital for Sick Children at Great Ormond-street, the Victoria Hospital for Children, the Hospital for Women, Soho-square, the Samaritan Free Hospital, the Cancer Hospital at Brompton, the Female Lock Hospital, Harrow-road, the Royal London Ophthalmic Hospital, Moorfields, the Bexhill Convalescent Home, All Saints' Convalescent Home at Eastbourne, the Royal Sea Bathing Infirmary, and the Indigent Blind Asylum; and £500 each to the North London Hospital for Consumption at Hampstead, the Royal Hospital for Diseases of the Chest, City-road, the Royal National Hospital at Ventnor, and St. Andrew's Home at Folkestone.

Parliamentary Intelligence.

NOTES ON CURRENT TOPICS.

The New Session.

It is very difficult to say what will be the course of the new session which the KING opened on Tuesday. Members have no better information on the subject than the man in the street; all are agreed, however, that anything may happen at any moment. During the last ten years no such state of uncertainty has existed. In the days immediately before the fall of the Rosebery Government in 1895 matters were almost as unsettled and unsettling but the complexity of the situation was as nothing compared with the situation to-day. In a week's time we shall have more data to go upon in estimating the chances.

Legislation.

The forecast of legislation contained in the King's speech reveals no unexpected proposals. It is practically an official confirmation of the various rumours that have been circulating for weeks. None of the proposals mentioned would directly affect the medical profession. For anything of that sort we shall look to the pigeon-holes of the departments. In one of these pigeon-holes we know there is to be found the Lunacy Bill which was introduced by the Government shortly before the close of last session. In due course this measure will doubtless again come before Parliament. As for other legislative proposals concerning the Faculty nothing can be said until the ballot for private Members' Bills takes place.

Sale of Tobacco to Children.

Dr. MACNAMARA will ask the Home Secretary on Monday whether his attention has been called to the recommendation of the Physical Deterioration (1904) Committee to the effect that a Bill should be brought before Parliament at an early date having for its object the prohibition of the sale of tobacco and cigarettes to children below a certain age, and whether he is now in a position to say that this recommendation will be acted upon in the present session.

Physical Deterioration.

In the beginning of the week several questions will be addressed to Ministers as to the recommendations of the Committee on Physical Deterioration. The object is to learn whether legislation will be proposed.

BOOKS, ETC., RECEIVED.

FISCHER, GUSTAV, Jena.

Lehrbuch der Allgemeinen Pathologie und der Pathologischen Anatomie. Für Aerzte und Studierende. Von Dr. Ernst Ziegler, Professor der Pathologischen Anatomie und der Allgemeinen Pathologie an der Universität Freiburg i.Br. Elfte neu bearbeitete Auflage. Erster Band. Allgemeine Pathologie. Price, paper, M.13; bound, M.15.

GREEN, WILLIAM, AND SONS, Edinburgh and London.

About Dreaming, Laughing, and Blushing. By Sir Arthur Mitchell, K.C.B. Price 5s. net.

HIRSCHWALD, AUGUST, Unter den Linden, 68, Berlin, N.W.

Sammlung Klinischer Abhandlungen über Pathologie und Therapie der Stoffwechsel- und Ernährungsstörungen. Herausgegeben von Prof. Dr. Carl von Noorden, Oberarzt des Städtischen Krankenhauses in Frankfurt a.M. 6 Heft. Ueber Durstcuren, besonders bei Fettleibigkeit. Von Dr. H. Salomon, Secundärarzt der Medicinischen Abtheilung des Städtischen Krankenhauses in Frankfurt a.M. Price M.1.20.

Lehrbuch der Speciellen Chirurgie für Aerzte und Studirende. Von Dr. Franz Koenig, Ord. Professor der Chirurgie, Geh. Med.-Rath Director der Chirurgischen Universitäts-Klinik und Poliklinik der Kgl. Charité in Berlin. Achte Auflage. III. Band. Price not stated.

J. B. LIPPINCOTT COMPANY, Philadelphia and London.

International Clinics. (A Quarterly). Edited by A. O. J. Kelly, A.M., M.D. Philadelphia, U.S.A., with Collaboration. Volume IV. Fourteenth Series. 1905. Price not stated.

KEGAN PAUL, TRENCH, TRÜBNER AND CO., LIMITED, Dryden House, 43, Gerrard-street, W.

Ambidexterity, or Two-handedness and Two-brainedness. An Argument for Natural Development and Rational Education. By John Jackson, F.E.I.S., Founder and Honorary Secretary of the Ambidextral Culture Society. With an Introduction by Major-General R. S. S. Baden-Powell, C.B. Price not stated.

KING, P. S., AND SON, Orchard House, Westminster, S.W.

Urban Police and Sanitary Legislation, 1904. Being a Collection of Provisions contained in the Local Improvement Acts obtained by English Urban District Councils in the Year 1904, after consideration by the Police and Sanitary Committee of the House of Commons. Compiled and arranged by Frank Noel Keen, of the Middle Temple, Barrister-at-Law. Price 10s. 6d. net.

LONGMANS, GREEN, AND CO., 39, Paternoster-row, E.C.

"X" Rays. A Collection of Papers communicated to the Academy of Sciences, with Additional Notes and Instructions for the Construction of Phosphorescent Screens. By R. Blondlot, Correspondent of the Institute of France, Professor in the University of Nancy. Translated by J. Garcin, Ingénieur, E.S.E., Licencié-ès-Sciences. With Phosphorescent Screen and other Illustrations. Price 3s. 6d. net.

Neolithic Dew-ponds and Cattle-ways. By Arthur John Hubbard, M.D., and George Hubbard, F.S.A., F.R.I.B.A. Price 3s. 6d. net.

MALOINE, A., 25-27, Rue de l'Ecole-de-Médecine, Paris.

De l'Endométrite et de la Métrite Parenchymateuse Infectieuses. (Etude Clinique et Thérapeutique.) Par le Dr. E. Ozenne, Ancien Interne des Hôpitaux, Ancien Chef de Clinique Adjoint de la Faculté, Chirurgien de Saint-Lazare. Price Fr.4.

L'Organisation de la Lutte contre la Tuberculose. Par Georges Lafargue. Price Fr.1.

La Guérison et la Prophylaxie de la Tuberculose au Sanatorium de Banyuls-sur-Mer. Par Georges Lafargue, Ancien Préfet, à Paris, Fondateur du Sanatorium de Banyuls. Price Fr.1. (Extraits des Comptes rendus de l'Association Française pour l'Avancement des Sciences, Congrès d'Angers, 1903.)

Le Béribéri: Définition, Etymologie, Historique, Bactériologie, Symptomatologie, Pathogénie, Pathologie Expérimentale, Traitement. Par le Dr. H. Vivian Dangerfield, de la Faculté de Médecine de Paris. Price Fr.12.

MURRAY, JOHN, 50A, Albemarle-street, W.

In Loco Parentis: Chapters on Institution Life and Work. By the Rev. Marshall George Vine, B.A., Warden and Resident Chaplain of the Philanthropic Society's Farm School, Redhill, Surrey. With a Preface by James Granville Legge, Esq., His Majesty's Chief Inspector of Home Office Schools. Price 2s. 6d. net.

SCIENTIFIC PRESS, LIMITED, 28 and 29, Southampton-street, Strand, W.C.

Elements of Anatomy and Physiology. Especially adapted for Nurses. By W. Bernard Secretan, M.B. Lond., F.R.C.S. Eng. L.R.C.P. Price 2s. net.

UNWIN, T. FISHER, 11, Paternoster-buildings, E.C.

Essays in Puritanism. By Andrew Macphail. Price 6s.

VIGOT FRÈRES, 23, Place de l'École-de-Médecine, Paris.

Les Indications des Interventions Chirurgicales dans les Maladies Internes. A l'Usage des Médecins Praticiens. Par le Professeur Dr. Hermann Schlesinger, de l'Université de Vienne. Traduction Française par les Docteurs L. Lichtwitz et J. Sabrazès de Bordeaux. Première Partie. Maladies du Système nerveux,

des Os et des Articulations, de la Plèvre, du Médiastin, du Système circulatoire, du Tube digestif. Price Fr.4.

Résurrection du Cœur; La Vie du Cœur isolé: le Massage du Cœur. Par le Dr. Maurice D'Halluin, Chargé des Travaux pratiques de Physiologie à la Faculté Libre de Médecine. Price not stated.

WOOD, WILLIAM, AND CO., 51, Fifth Avenue, New York.

The Influence of Growth on Congenital and Acquired Deformities. By Adoniram Brown Judson, A.M., M.D., Orthopædic Surgeon to the Out-patient Department, New York Hospital, 1878-1903. Price not stated.

Appointments.

Successful applicants for Vacancies, Secretaries of Public Institutions, and others possessing information suitable for this column, are invited to forward to THE LANCET *Office, directed to the Sub Editor, not later than 9 o'clock on the Thursday morning of each week, such information for gratuitous publication.*

BROADBENT, JOHN F. H., M.D. Oxon., has been appointed Physician in Charge of Out-patients at St. Mary's Hospital, Paddington, W.

BROWN, A., L.R.C.P.I., M.R.C.S. Eng., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Masham District of the county of York.

BROWNE, ADA M., L.S.A., has been appointed Anæsthetist to the Chelsea Hospital for Women.

BURGHARD, F. F., M.D., M.S. Lond., F.R.C.S. Eng., has been appointed Consulting Surgeon to the Bromley Cottage Hospital.

BURTON-BROWN, F. H., M.D. Oxon., has been appointed Clinical Assistant to the Chelsea Hospital for Women.

DOORLY, P. F., L.R.C.P., L.R.C.S. Edin., L.F.P.S.G., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Carrick-on-Shannon No. 2 District of the county of Roscommon.

FORTESCUE-BRICKDALE, J. M., M.A., M.D. Oxon., has been appointed Out-patient Physician and Pathologist to the Royal Hospital for Sick Children and Women, Bristol.

FRAMPTON, TREVETHAN, F.R.C.P. Edin., has been appointed Clinical Assistant to the Chelsea Hospital for Women.

GEDGE, ARTHUR SYDNEY, M.R.C.S., L.R.C.P. Lond., has been appointed Medical Officer for the Fifth District of the Devizes Union.

HARRIS, WILFRED J., M.D. Cantab., has been appointed Physician in Charge of Out-patients at St. Mary's Hospital, Paddington, W.

HEATH, P. MAYNARD, B.S., F.R.C.S., has been appointed Surgical Registrar to University College Hospital.

LAURIE, A. M., L.R.C.P. & S. Edin., has been appointed Parochial Medical Officer and Public Vaccinator for the joint parishes of Houston and Killellan, Renfrewshire.

LAWRIE, W. J., M.D., C.M. Glasg., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Ayr District of the county of Ayr.

LYLE, H. WILLOUGHBY, M.D., B.S. Lond., F.R.C.S. Eng., has been appointed Consulting Ophthalmic Surgeon to the Bromley Cottage Hospital.

PERCIVAL, A. P., M.B., C.M. Edin., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Knottingley District of the county of York.

SYKES, WALTER, L.R.C.P., L.R.C.S., L.F.P.S.G., has been appointed Honorary Ophthalmic and Aural Surgeon to the Preston and County of Lancaster Royal Infirmary.

Vacancies.

For further information regarding each vacancy reference should be made to the advertisement (see Index).

AYLESBURY, ROYAL BUCKINGHAMSHIRE HOSPITAL.—House Surgeon, unmarried. Salary £100 per annum, rising to £120, with board and apartments.

BARNSLEY, YORKSHIRE, BECKETT HOSPITAL.—Resident House Surgeon. Salary £100 per annum, with board, lodging, and washing.

BETHNAL GREEN INFIRMARY AND WORKHOUSE.—Assistant Medical Officer. Salary £100 per annum, with apartments, board, and washing.

BIRKENHEAD AND WIRRAL CHILDREN'S HOSPITAL, Woodchurch-road, Birkenhead.—House Surgeon. Honorarium £100, with board, residence, and laundry.

BRIDGWATER INFIRMARY.—House Surgeon. Salary £80 a year, with board and residence.

BRIGHTON THROAT AND EAR HOSPITAL, Church-street, Queen's-road.—Non-Resident House Surgeon for six months, renewable. Salary at rate of £75 per annum.

CANCER HOSPITAL, Fulham-road, London, S.W.—Assistant House Surgeon for six months, renewable. Salary £70 per annum, with board and residence.

CHELTENHAM GENERAL HOSPITAL.—Junior House Surgeon, unmarried. Salary £50 per annum, with board, lodging, and washing. Also Surgeon-in-Charge of the Branch Dispensary, unmarried. Salary £90 per annum, with board, lodging, and washing.

CITY OF LONDON HOSPITAL FOR DISEASES OF THE CHEST, Victoria-park, E.—Two House Physicians for six months. Salary at rate of £30 per annum, with board and residence.

DENBIGH, DENBIGHSHIRE INFIRMARY.—House Surgeon. Salary £100, with board, residence, and washing.

DURHAM COUNTY HOSPITAL.—House Surgeon. Salary £120, with board and lodging.

EAST LONDON HOSPITAL FOR CHILDREN AND DISPENSARY FOR WOMEN, Shadwell, E.—Medical Officer for six months, renewable. Salary at rate of £100 per annum, with luncheon. Also House Surgeon for six months. Honorarium £25, with board, residence, &c.

EVELINA HOSPITAL FOR SICK CHILDREN, Southwark, S.E.—Physician to Out-patients. Also Eight Qualified Clinical Assistants, out-patient department.

FRENCH HOSPITAL, London.—Honorary Physician.

HARTLEPOOLS HOSPITAL.—House Surgeon. Salary £100 per annum, with board, washing, and lodging.

KENSINGTON WORKHOUSE AND INFIRMARY.—First Assistant Resident Medical Officer. Salary £120 per annum, rising to £150, with apartments, board, and washing.

LEEDS GENERAL INFIRMARY.—Resident Surgical Officer. Salary £100 per annum, with board, residence, and washing.

LINCOLN COUNTY HOSPITAL.—Senior House Surgeon, unmarried. Salary £100 per annum, with board, lodging, and washing.

LISTER INSTITUTE OF PREVENTIVE MEDICINE, Chelsea, S.W.—Jenner Memorial Studentship in Bacteriology. Value £150.

LIVERPOOL INFIRMARY FOR CHILDREN.—Assistant House Surgeon for six months. Salary £30, with board and lodging.

MACCLESFIELD GENERAL INFIRMARY.—Junior House Surgeon. Salary £50 per annum, with board and residence.

MANCHESTER ROYAL INFIRMARY.—House Physician, unmarried, for six months.

MEDICAL DEPARTMENT OF THE NAVY, 18, Victoria-street, London, S.W.—Three Dental Surgeons. Salary £1 per diem.

NORFOLK AND NORWICH HOSPITAL.—Second Assistant House Surgeon for six months. Honorarium £20, with board, lodging, and washing.

NORTH-EASTERN HOSPITAL FOR CHILDREN, Hackney-road, Bethnal Green, E.—Pathologist and Bacteriologist. Salary £50 per annum, with lunch.

OXFORD, RADCLIFFE INFIRMARY.—Junior House Surgeon, unmarried, for six months. Salary at rate of £40 per annum, with board, &c.

PAISLEY, ROYAL ALEXANDRA INFIRMARY, Barbour Park.—Assistant House Surgeon. Salary £40, with bed and board.

PARISH OF HAMMERSMITH.—Medical Officer and Public Vaccinator. Salary at rate of £80 per annum and fees.

QUEEN'S JUBILEE HOSPITAL, Earl's Court, S.W.—One Surgeon; one Physician; one Nose, Throat and Ear; one Gynæcologist; and one Ophthalmic Surgeon. All honorary.

READING, ROYAL BERKSHIRE HOSPITAL.—Assistant House Surgeon. Salary £80 per annum, with board, lodging, and washing.

ROYAL LONDON OPHTHALMIC HOSPITAL, City-road, E.C.—Curator and Librarian. Salary £120 a year.

ST. MARYLEBONE GENERAL DISPENSARY, 77, Welbeck-street, Cavendish-square.—Honorary Physician.

SHEFFIELD, EAST-END BRANCH OF THE CHILDREN'S HOSPITAL.—House Surgeon. Salary £70 per annum, with board, lodging, and washing.

STAFFORD, STAFFORDSHIRE GENERAL INFIRMARY.—Assistant House Surgeon for six months. Honorarium of £41, with board, residence, and laundry.

STOCKPORT INFIRMARY.—Assistant House and Visiting Surgeon. Salary £80 per annum, with board, washing, and residence.

TEIGNMOUTH HOSPITAL, S. Devon.—House Surgeon. Salary £70 a year, with board, lodging, and washing.

WESTMINSTER GENERAL DISPENSARY.—Honorary Surgeon.

WISBECH, NORTH CAMBRIDGESHIRE HOSPITAL.—Resident Medical Officer, unmarried. Salary £100 per annum, with rooms, attendance, coal, and gas.

WREXHAM INFIRMARY.—Resident House Surgeon. Salary £80 per annum, with board, lodging, and washing.

YORKSHIRE INEBRIATES' REFORMATORY, Cattal, near York.—Medical Superintendent. Salary £250 per annum, with residence, rations, coal, light, and washing.

Births, Marriages, and Deaths.

BIRTHS.

KELYNACK.—At Northwood, Middlesex, on Feb. 1st, Violet Kelynack (*née* Violet McLaren, M.B., Ch.B. Edin.), the wife of T. N. Kelynack, M.D., M.R.C.P., of 120, Harley-street, Cavendish-square, W., of a daughter.

LAUCHLAN.—On Feb. 10th, at Lower Richmond-road, Putney, S.W., the wife of Henry D. Lauchlan, L.R.C.P. & S.E., of a daughter.

MARKS.—On Feb. 6th, at Rosebank, Mumbles, Glamorganshire, the wife of L. Freeman Marks, M.B., M.R.C.S., of a daughter.

NEIL.—On Feb. 13th, at Church-lane, Hornsey, N., the wife of William Herbert Neil, M.R.C.S., L.R.C.P., of a son.

SINGER.—On Jan. 24th, at Omaha, Nebraska, U.S.A., the wife of H. Douglas Singer, M.D., M.R.C.P. Lond., of a daughter.

SUTCLIFFE.—On Feb. 11th, at St. Helier, Norfolk-road, Seven Kings, Essex, the wife of W. H. Sutcliffe, L.R.C.P.I., of a daughter.

WEBB.—On Feb. 9th, at Westbourne House, Westbrook, Margate, the wife of Cholmondeley Webb, M.R.C.S., L.R.C.P. Eng., of a son.

MARRIAGE.

LEON—FRIEND.—On Feb. 9th, 1905, at All Souls, Langham-place, John Temple Leon, M.D., of Elmwood, Southsea, to Katherine Mary Friend.

DEATHS.

BOTHWELL.—On Feb. 11th, 1905, George Granville Bothwell, M.B., C.M. Aber. 1891, of Great Chalvedon Hall, Pitsea, Essex, aged 34.

ROOSE.—On Feb. 12th, R. C. Robson Roose, M.D., LL.D., F.R.C.P. Edin., of Hill-street, Berkeley-square, in his 57th year.

WALSH.—On Feb. 7th, at Mer Vue, Booterstown, co. Dublin, Surgeon-Major-General T. Walsh, retired, A.M.S., in his 67th year.

N.B.—A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.

Notes, Short Comments, and Answers to Correspondents.

THE REJECTION OF A FELLOW PRACTITIONER'S OPINION.

AT a recent inquest at Battersea the conduct of Miss Chisholm, a lady whose qualification to practise medicine dates from July last, formed the subject of unfavourable comment by the coroner, Mr. Troutbeck, and of a rider by the jury over whose deliberations he presided. The wife of a labourer had been attended in her confinement by two nurses from the Battersea Maternity Home. Four days later she developed unfavourable symptoms and on his return from work her husband found her seriously ill with Miss Chisholm in attendance. Actuated by a desire to do the best for his wife and possibly not satisfied with the experience of the lady the husband called in a medical man, Mr. H. W. Joyce, who consulted with her and offered suggestions as to treatment. These, however, Miss Chisholm deliberately declined to follow and she herself admitted this at the inquest, saying that she had not agreed with Mr. Joyce's diagnosis which, however, was proved to have been perfectly correct at the post-mortem examination made by Dr. L. Freyberger. In the circumstances it was not surprising that the jury blamed Miss Chisholm for taking upon herself a grave responsibility followed by a fatal termination of the case which she was attending and the finding of the jury was a repetition of observations made by Mr. Troutbeck in addressing them. We concur in the view that the lady's conduct as the event turned out was extremely injudicious and that to set her own opinion without any confirmation of it against that of a practitioner of far greater experience than her own was likely to lead to disaster. We would, however, ask Mr. Troutbeck to consider whether he himself during his tenure of the coroner's office in the South-Western district in which he acts has done anything to uphold or to increase the respect in which a newly qualified practitioner would hold his or her seniors practising in that locality. We have referred to Dr. Freyberger as having made the post-mortem examination which was naturally required in the case under comment, but we are not aware of anything in the evidence which he founded upon his observations that might not have been laid before the jury with equal authority by a medical man practising in the locality. The only difference between the employment of such a one and that of Dr. Freyberger would have been in the matter of legality. The former course would have been sanctioned by the Coroners Act and that adopted was not. Miss Chisholm, no doubt, acted wrongly but she treated the views of Mr. Joyce with at least as much respect as Mr. Troutbeck has accorded to those of the medical practitioners of Battersea during the past few years.

FLANNELETTE.

To the Editors of THE LANCET.

SIRS,—My attention has been called to two articles in your columns of Jan. 21st and Feb. 4th under the above title. As a chemist with many years' experience in the production of flannelette of all kinds, including that of the "Non-Flam" alluded to in one of the articles, may I be allowed a few remarks upon the matter. The many qualities of flannelette such as softness, warmth, cheapness, would make it an ideal material for many purposes were it not for its one great and terrible defect of easy inflammability. Attempts have been made in many ways to remedy or to minimise this, but the only one which has not one or other objection to it seems to be that of producing a permanently safe flannelette. Some remedies such as fireguards and sleeping sacks for children, both discussed in THE LANCET of Feb. 4th, though good, have the failing of being only protective on occasions. A proportion, a large proportion, no doubt, of burning accidents would be prevented by a more frequent use of fireguards, but there are many such burning cases happen without actual contact with a fire or a burning cinder from one. The use of sleeping sacks would also do its share of prevention, but one frequently sees reports of cases of burning due to the day-time wear of flannelette under-garments. "Surgeon's" method of soaking the goods after each washing in a solution of alum (or other salts) one often comes across in print. But I believe the people who advocate this remedy simply waste their time. I never knew or heard of a case of the treatment being tried; I suppose the extra trouble required, and perhaps the expense of doing this constantly weekly or even oftener, is against it. There is no denying the fact that flannelette is the most dangerous fabric in common wear and is responsible for a vast number of burning accidents, invariably of the most distressing nature, though actual experience of one seems necessary to convince a great many people of this; or at least "Surgeon" must be one of a very few people who deny that flannelette is more inflammable than other cotton goods. Possibly his tests with it have been confined to a sample of newly bought flannelette, still containing its finishing salts and more than normally damp. If so, I think that if he had washed it (cold water would have been sufficient) and thoroughly dried it he would have come to the same conclusion as the writer of the article of Jan. 21st who says that children wearing this stuff are exposed "to the same risk as if their nightdresses were soaked in spirit." What is the remedy for this? To my mind there is only one which will meet all cases—viz., a permanently safe flannelette: "Non-Flam," or any other still better when it makes its appearance. At present "Non-Flam" is the only one before the public. It has been there for nearly three years and may surely claim to have been well tested in that time. How does it come out of the test? Is it what the manufacturers claim for it—a flannelette with all the good properties of the ordinary dangerous stuff, with several of them still bettered, only a trifle dearer (practically none if its increased thickness and wearing quality are taken into account) and as permanently safe as if made of wool instead of cotton? The opinion expressed in your article of Feb. 4th, after experiments with the cloth supplied by "Surgeon" himself, is that "there is little doubt that its inflammability is practically *nil*." Coroners throughout the country have approved of it; some of them have demonstrated its properties at inquests of burning fatalities. No word of complaint has ever reached the manufacturers of its failure to reach the standard which they have made. They have in their possession garments returned to them by customers—made from stuff bought from drapers in the usual way—which have been in constant wear for two years or over and have been washed some scores of times and are still as little inflammable as if made of flannel.

I have alluded to the price of this article. If "Surgeon" has paid 7*d.* for a fire-proofed flannelette which, if made of the ordinary stuff, would only have cost him 2½*d.*, he has been badly imposed upon. The cost of proofing is only about 1*d.* per yard; in the heaviest and most expensive cloths not more than 1½*d.* If "Surgeon's" draper has added 3½*d.* or so on to the usual price for the material because it was fire-proofed he has made a very fair profit for himself. And even, as before stated, this extra cost of 1*d.* per yard for proofing is practically covered by the better wearing qualities and feel of the article. This is specially noticeable after the first wash. For whilst the finishing materials in ordinary flannelettes wash out that of the "Non-Flam" remains. It is an *oxide* of tin, not a *salt* as stated in the article of Feb. 4th. If left uncorrected this might give an impression that the proofing would have an unpleasant or injurious effect upon the skin, which is not so; an oxide which enters into a close, probably a chemical, combination with the cotton fibre and is insoluble in ordinary washing reagents. Hence it remains as a perfect proofing and finish in the cloth.

I am, Sirs, yours faithfully,

Castleton, Lancs., Feb. 7th, 1905. S. BRADBURY.

"WHAT APPENDICITIS IS."

IN reference to the note which appeared under the above heading in our issue of Feb. 11th, a correspondent sends us a cutting from an article which appeared in the *Evening News* at the time of the illness of the King in 1902. The passage is concerned with information supplied by a medical correspondent to the Central News "on perityphlitis, the complaint from which the King is suffering." After giving a perfectly sound definition of perityphlitis the medical correspondent is made to say: "In ordinary language, it is inflammation of the outer intestine, or the channel which, when it collapses, gives rise to rupture of the stomach." We referred to other ludicrous mistakes made by the lay press at the time of His Majesty's illness in a leading article in THE LANCET of July 5th, 1902. Another mistake which we well remember and which was correctly incorrect was that made in a newspaper report of the death of some notability a few years ago to the effect that the breathing showed the *change stroke*. This very happy metonymy for Cheyne Stokes was a masterpiece of blundering.

THE TREATMENT OF JOINTS ON BIER'S METHOD.

To the Editors of THE LANCET.

SIRS,—Can any of your readers tell me where I can find a full description of Bier's method of treatment of various joint affections by elastic constriction? I am, Sirs, your faithfully,

Feb. 14th, 1905. ENQUIRENS.

NAMES OF HOSPITALS AND SOCIETIES.

A CORRESPONDENT writes to point out that "a good deal has been said lately about hospitals economising," and he thinks that "it would be well if a little attention were turned to the economy of names by those who have the duty of choosing and finally selecting the name or names to be bestowed upon hospitals and societies. The tendency seems to be nowadays to shorten names and if they are not shortened officially they are unofficially, and one example will be fresh in the minds of readers of THE LANCET—viz., that of Epsom College, which title after having been used unofficially for some time has now become official. Everybody knows how 'The Hospital for Consumption and Diseases of the Chest, Brompton, S.W.,' has become unofficially shortened to 'Brompton Hospital.' Time is too short now to give institutions with long names their full official titles such as 'Hospital for Epilepsy and Paralysis and Other Diseases of the Nervous System, Maida Vale.' It would also seem to have a financial aspect, for when a man is making his will or has money to distribute it is far more likely that he will think of 'Brompton Hospital' or some hospital with a short title than of the title of a hospital with about 14 words in it and it is undoubtedly necessary in such cases to be strictly accurate in describing which hospital is meant. It is well known how the memory of names influences a person's decision in the daily walks of life. Advertisers of pickles, sauces, and soap, and other wares know it full well and take care to present to the eye at every turn the name of their particular product. Also there is the question of economy in the matter of printing and advertising the hospital's

needs and painting its name on boards and so on. This is exemplified by the action of the Great Eastern Railway Company which used to paint on each side of every one of its coaches the letters G.E.R., followed by the number, but it may be observed that all the new six-a-side coaches have only the letters G.E., followed by the number."

THE PROGRESSIVE MEDICAL ALLIANCE.

DURING the trial on Feb. 10th at the Central Criminal Court of a man named Holmes for uttering a forged cheque some interesting facts came out about the Progressive Medical Alliance, a quack establishment run by a man calling himself Dr. Talbot Bridgwater, who gave evidence for the defence. Bridgwater said that he carried on business as the Progressive Medical Alliance at 57 and 59, Oxford-street. He was a consulting specialist and had an American diploma. He had been in Australia and had received testimonials from Sir Harry Parkes. In cross-examination he said that he remembered that at various times men employed to deliver his leaflets had been prosecuted and fined for circulating indecent literature. Probably as many as 50 men had been fined. He paid the fines himself as a rule. Last year he had employed a man named Shackell. He knew that Shackell had made a *faux pas*, something in connexion with forging a bill of exchange for £500. He knew Billy Wigram and a man named Robertson. It was exceedingly possible that these two together with a third man had been sentenced at Glasgow to five years' penal servitude for robbing a stockbroker's clerk. He did not provide Wigram with funds for his defence but a man named Haines who had been in his (Bridgwater's) employ, did, he believed, go to Glasgow with money for the defence, which money had been subscribed by some betting men. He came across all sorts of people as patients. Dr. McDonach who was advertised in connexion with his business was Eliza McDonach and one of the women doctors first qualified in London. He did not know where she was now but she was the same as Madame Frickart, having married a man of that name. In the end the jury disagreed but Bridgwater's admissions certainly throw light on the Progressive Medical Alliance. The name of Macdonagh-Frickhart, Eliza Foster, registered as Lic., Lic. Midwif. 1879, K.Q. Coll. Phys. Irel.; M.D. Univ. Zurich, was erased from the Medical Register, May 23rd, 1894, by order of the General Medical Council. Minutes, vol. xxx., 138; xxxi., 59.

THE CASE OF DR. A. D. GRIFFITHS.

To the Editors of THE LANCET.

SIRS,—May I be allowed to announce the following further contributions to the above fund?—Amount previously acknowledged, £37 4s.; Mr. T. Carwardine, £1 1s.; Dr. S. Hamilton, 10s.

I am, Sirs, yours faithfully,
ALEXR. P. FIDDIAN, Treasurer.

23, The Walk, Cardiff, Feb. 14th, 1905.

WANTED—A HOME.

A MEDICAL man residing near London is anxious to discover a home for a man, aged 48 years, who has epileptic fits at long intervals. Between the seizures he is tractable, inoffensive, and fully intelligent. He has a pension for life of £20 per annum and would willingly accept employment to help to defray the cost of keeping him. His relatives are educated people who cannot now afford to keep him. The inquirer will be glad if any of our readers who can help him will address Mr. Frank Collins, Sproxton, Wanstead.

WHAT THE LANCET HAS NOT SAID.

WE receive material for a weekly article which could justifiably be published under the above title, for no week goes by without our attention being drawn to the wiles of some enterprising advertiser who is asserting that his wares have received a special commendation from us which the facts do not warrant. Our attention has now been called to the fact that a company calling itself the American Tobacco Company of Canada, Limited, is advertising its "Sweet Caporal" cigarettes as "the purest form in which tobacco can be smoked (London LANCET)." We have never said anything of the kind concerning these cigarettes nor have we singled out any cigarette as being composed of the purest tobacco. Some two years ago we made an investigation into the tobaccos employed by a certain number of cigarette manufacturers with the result that we were able to clear Virginian cigarettes from certain accusations of gross adulteration, and we presume that some of the words in our article are held by the American Tobacco Company of Canada to justify its advertisement. Of course, they do nothing of the sort.

SCIENCE ON THE STAGE.

CHEMICAL and physical phenomena have an undoubted attraction for the public and our variety entertainment managers would appear to be vieing with each other just now to exhibit the latest chemical or physical sensation. The magic kettle created considerable interest but it was merely a popular exposition of some of the properties of liquid air. As a completely diametrical set-off to this the public are to be regaled with a demonstration at the London Pavilion of a method for the production of intense heat without the aid of the usual appliances, a blow-pipe even, or the oxyhydrogen flame, or the blast furnace. The method is well known to chemists and engineers and depends upon the intense heat set up by the combustion of a given element at the expense of oxide of iron mixed with it. The combustion is intense and molten iron remains. By this means it is stated that liners or warships may carry an equipment represented in a small heap of powder which will enable them to repair a broken shaft or a propeller. The most striking experiment at the London Pavilion is, perhaps, that in which it is shown that the molten iron produced will fall through cold water and then pierce through an iron plate serving as a bottom to the vessel containing the water. A mixture known as thermit was described in THE LANCET of Feb. 20th, 1904, p. 548, which will give the results mentioned. The combustion of the aluminium at the expense of the ferric oxide is actuated in the case of thermit by means of a mixture of peroxide of barium and metallic aluminium. The heat produced is very intense, the temperature being estimated to be 3000° C. Holes are melted in boiler-plates with the greatest ease, the heat of the oxyhydrogen flame is not equal to thermit, though the heat of the electric arc may be. A mere heap of powder, however, is simplicity itself compared with these appliances.

THE WEIR-MITCHELL TREATMENT AND LING'S EXERCISES.

To the Editors of THE LANCET.

SIRS,—Will any of your readers kindly inform me where I can obtain full particulars of treatment of cases of neurasthenia by Weir-Mitchell rest treatment, also by Ling's resistance exercises?

I am, Sirs, yours faithfully,
M.D. BRIT.

Feb. 13th, 1905.

*** An account of the Weir-Mitchell rest treatment by the late Dr. Playfair is given in an article on Hysteria in Tuke's "Dictionary of Psychological Medicine."—ED. L.

ARE ENGLISH PERIODICALS CORRUPT?

A GENIAL paper, the *Chicago House Beautiful*, appears to be telling its audience that "The Lancet will praise your table waters ..... possibly all the world understands these statements are worth not more than the 6d. a line that they cost." It does not signify to us what stupid lies a paper like the *Chicago House Beautiful* may print concerning us but it is interesting to find how rooted is the belief of the American editor in British corruption. It has not struck the editor of the *Chicago House Beautiful* that, considerations of morality apart, for THE LANCET to receive money in return for making analyses would be a disastrous proceeding, inasmuch as the venality could not remain concealed and the value of the analyses, and indeed of every opinion expressed by the journal, would at once cease to exist. In America, where editorial opinion is in many cases not worth a cent., and where many journals are to all intents owned by their advertisers, the strength of an independent position is so little realised that it becomes unimaginable.

M.B., C.M.—If the dentist in question is on the Dental Register his proceedings are correct but we agree with our correspondent in thinking that many dentists take undue risks in the matter of the administration of anæsthetics. Many general practitioners expressly refuse dental cases.

J. H.—The necessity varies with the size of the room and the facilities for ventilation.

Mr. A. Gavin.—Will our correspondent who addressed a question to us recently from Symington kindly send us his address?

Medical Diary for the ensuing Week.

OPERATIONS.

METROPOLITAN HOSPITALS.

MONDAY (20th).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), St. George's (2 P.M.), St. Mary's (2.30 P.M.), Middlesex (1.30 P.M.), Westminster (2 P.M.), Chelsea (2 P.M.), Samaritan (Gynæcological, by Physicians, 2 P.M.), Soho-square (2 P.M.), Royal Orthopædic (2 P.M.), City Orthopædic (4 P.M.), Gt. Northern Central (2.30 P.M.), West London (2.30 P.M.), London Throat (9.30 A.M.), Royal Free (2 P.M.), Guy's (1.30 P.M.).

TUESDAY (21st).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), Guy's (1.30 P.M.), Middlesex (1.30 P.M.), Westminster (2 P.M.), West London (2.30 P.M.), University College (2 P.M.), St. George's (1 P.M.), St. Mary's (1 P.M.), St. Mark's (2.30 P.M.), Cancer (2 P.M.), Metropolitan (2.30 P.M.), London Throat (9.30 A.M.), Royal Ear (3 P.M.), Samaritan (9.30 A.M. and 2.30 P.M.), Throat, Golden-square (9.30 A.M.), Soho-square (2 P.M.), Chelsea (2 P.M.), Central London Throat and Ear (2 P.M.).

WEDNESDAY (22nd).—St. Bartholomew's (1.30 P.M.), University College (2 P.M.), Royal Free (2 P.M.), Middlesex (1.30 P.M.), Charing Cross (3 P.M.), St. Thomas's (2 P.M.), London (2 P.M.), King's College (2 P.M.), St. George's (Ophthalmic, 1 P.M.), St. Mary's (2 P.M.), National Orthopædic (10 A.M.), St. Peter's (2 P.M.), Samaritan (9.30 A.M. and 2.30 P.M.), Gt. Ormond-street (9.30 A.M.), Gt. Northern Central (2.30 P.M.), Westminster (2 P.M.), Metropolitan (2.30 P.M.), London Throat (9.30 A.M.), Cancer (2 P.M.), Throat, Golden-square (9.30 A.M.), Guy's (1.30 P.M.).

THURSDAY (23rd).—St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), University College (2 P.M.), Charing Cross (3 P.M.), St. George's (1 P.M.), London (2 P.M.), King's College (2 P.M.), Middlesex (1.30 P.M.), St. Mary's (2.30 P.M.), Soho-square (2 P.M.), North-West London (2 P.M.), Gt. Northern Central (Gynæcological, 2.30 P.M.), Metropolitan (2.30 P.M.), London Throat (9.30 A.M.), St. Mark's (2 P.M.), Samaritan (9.30 A.M. and 2.30 P.M.), Throat, Golden-square, (9.30 A.M.), Guy's (1.30 P.M.).

FRIDAY (24th).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), Guy's (1.30 P.M.), Middlesex (1.30 P.M.), Charing Cross (3 P.M.), St. George's (1 P.M.), King's College (2 P.M.), St. Mary's (2 P.M.), Ophthalmic (10 A.M.), Cancer (2 P.M.), Chelsea (2 P.M.), Gt. Northern Central (2.30 P.M.), West London (2.30 P.M.), London Throat (9.30 A.M.), Samaritan (9.30 A.M. and 2.30 P.M.), Throat, Golden-square (9.30 A.M.), City Orthopædic (2.30 P.M.), Soho-square (2 P.M.), Central London Throat and Ear (2 P.M.).

SATURDAY (25th).—Royal Free (9 A.M.), London (2 P.M.), Middlesex (1.30 P.M.), St. Thomas's (2 P.M.), University College (9.15 A.M.), Charing Cross (2 P.M.), St. George's (1 P.M.), St. Mary's (10 P.M.), Throat, Golden-square (9.30 A.M.), Guy's (1.30 P.M.).

At the Royal Eye Hospital (2 P.M.), the Royal London Ophthalmic (10 A.M.), the Royal Westminster Ophthalmic (1.30 P.M.), and the Central London Ophthalmic Hospitals operations are performed daily.

SOCIETIES.

MONDAY (20th).—MEDICAL SOCIETY OF LONDON (11, Chandos-street, Cavendish-square, W.).—9 P.M. Dr. G. H. Savage: Toxic Mental Disorders. (Lettsomian Lecture.)

TUESDAY (21st).—PATHOLOGICAL SOCIETY OF LONDON (20, Hanover-square, W.).—8.30 P.M. Papers:—Dr. A. Lorand (Budapest): Blood Glands as Pathogenic Factors in the Production of Diabetes and Obesity.—Dr. C. H. Melland: Leucocythæmia with Change of Type from Splenomedullary to Lymphatic.—Dr. A. Dalton: Patchy Syphilitic Cirrhosis in an Infant.—Dr. J. Fawcett: Carcinoma of Cardiac Orifice of Stomach.—Mr. S. G. Shattock: Prehistoric Calculus. Card Specimen:—Dr. F. Price: Gangrene of Lung.

WEDNESDAY (22nd).—HUNTERIAN SOCIETY (London Institution, Finsbury-circus, E.C.).—8.30 P.M. Paper:—MR. A. H. Tubby.

FRIDAY (24th).—CLINICAL SOCIETY OF LONDON (20, Hanover-square, W.).—8 P.M. Exhibition of Clinical Cases followed by Discussion. Patients will be in attendance from 8 to 9 P.M.

LECTURES, ADDRESSES, DEMONSTRATIONS, &c.

MONDAY (20th).—MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies-street, W.C.).—4 P.M. Dr. H. G. Adamson: Clinique. (Skin.) 5.15 P.M. Dr. E. Cautley: Paratyphoid Fever.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith-road, W.).—5 P.M. Mr. Baldwin: Practical Surgery.

TUESDAY (21st).—MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies-street, W.C.).—4 P.M. Dr. G. A. Sutherland: Clinique. (Medical.) 5.15 P.M. Mr. P. Paton: Infective Diseases of Joints.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith-road, W.).—5 P.M. Dr. C. B. Ball: Some Complications of Middle-ear Suppuration (illustrated by lantern slides).

NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC (Queen-square, Bloomsbury, W.C.).—3.30 P.M. Sir W. Gowers: The Nature of Tabes.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 P.M. Lecture:—Dr. G. N. Meachen: Seborrhœa and Seborrhœic Dermatitis.

ROYAL INSTITUTION OF GREAT BRITAIN (Albemarle-street, W.).—5 P.M. Prof. L. C. Miall: The Structure and Life of Animals.

WEDNESDAY (22nd).—MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies-street, W.C.).—4 P.M. Mr. A. H. Tubby: Clinique. (Surgical.) 5.15 P.M. Dr. P. Horrocks: A Case of Concealed Menstruation with Remarks on Treatment.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith-road, W.).—5 P.M. Dr. Beddard: Practical Medicine.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn-road, W.C.).—5 P.M. Demonstration:—Dr. W. Wingrave: Ear.

HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (Brompton).—4 P.M. Dr. Maguire: Emphysema.

THURSDAY (23rd).—MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies-street, W.C.).—4 P.M. Mr. Hutchinson: Clinique. (Surgical.) 5.15 P.M. Mr. H. Clarke: Ocular Headache: its Causes, Diagnosis, and Treatment.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith-road, W.).—5 P.M. Mr. S. Edwards: Urinary Cases.

CHARING CROSS HOSPITAL.—4 P.M. Dr. Hunter: Demonstration of Medical Cases. (Post-Graduate Course.)

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7, Fitzroy-square, W.).—5 P.M. Lecture: Dr. T. N. Kelynack: The Diagnosis and Treatment of Pulmonary Cavities. (Post-Graduate Course.)

SAMARITAN FREE HOSPITAL FOR WOMEN (Marylebone-road, N.W.).—3 P.M. Mr. Malcolm: Some Points in Pelvic Diagnosis.

THE HOSPITAL FOR SICK CHILDREN (Gt. Ormond-street, W.C.).—4 P.M. Lecture:—Dr. Garrod: Hæmaturia and Albuminuria in Children.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 P.M. Dr. G. N. Meachen: Demonstration of Skin Cases.

FRIDAY (24th).—MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies-street, W.C.).—4 P.M. Dr. I. Lack: Clinique. (Throat.)

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith-road, W.).—5 P.M. Mr. C. Williams: The Finsen and Ultra-Violet Light Treatment.

NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC (Queen-square, Bloomsbury, W.C.).—3.30 P.M. Dr. A. Turner: Selected Cases.

ROYAL INSTITUTION OF GREAT BRITAIN (Albemarle-street, W.).—9 P.M. Prof. M. Ward: Fungi.

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MANAGER'S NOTICES.

THE INDEX TO THE LANCET.

THE Index to Vol. II. of 1904, which was completed with the issue of Dec. 31st, and the Title-page to the Volume, were given in THE LANCET of Jan. 7th.

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METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET Office, Feb. 16th, 1905.

Date.	Barometer reduced to Sea Level and 32° F.	Direction of Wind.	Rainfall.	Solar Radiation in Vacuo.	Maximum Temp. Shade.	Min. Temp	Wet Bulb.	Dry Bulb.	Remarks at 8.30 A.M.
Feb. 10	30·35	W.	...	66	52	44	43	45	Fine
,, 11	30·35	N.W.	...	79	46	39	38	39	Fine
,, 12	30·53	N.W.	...	50	42	37	35	37	Cloudy
,, 13	30·43	N.W.	...	56	52	34	41	42	Cloudy
,, 14	30·46	N.	0·06	64	53	42	48	49	Overcast
,, 15	30·52	W.	...	71	51	46	44	47	Cloudy
,, 16	30·30	W.	0·03	72	53	47	48	49	Cloudy

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